Psychoanalytic Practice: Clinical Studies

Transference and Relationship

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Introduction

The headings of the sections in this chapter do not correspond exactly to those in the second chapter of Vol. 1, which is a systematic historical treatise on the all-encompassing themes of transference and relationship. As important as it is to illustrate concepts by referring to precise examples, it is just as important not to lose sight of the fact that concepts do not lead lives of their own but rather place emphasis on significant connections in chains of events. It therefore seems logical to consider several examples of transference from the perspective of resistance (see Chap.4).

In this introduction we will restrict ourselves to a few words about major issues. The initial task in analysis is to create a "helping alliance" (Luborsky 1984); once this has been achieved, the psychoanalytic process is characterized by the interplay between transference and the working alliance (Sect. 2.1). The analyst's contribution toward creating favorable conditions for change is a special object of our interest. It seems obvious that we should choose examples from the initial phase of therapy as it is in this phase that the patient attempts to come to terms with the strange and unsettling situation. The patient's hopes that analysis will help him become better able to cope with the problems in his life are nourished by the experiences he has in the analytic situation.

The interplay of working alliance and transference is described in more detail in Sect. 2.2, and the patient's identification with the psychoanalyst and his functions is illustrated by a detailed example in Sect. 2.4.

The feature specific to the psychoanalytic theory of transference is the revival of past experiences in transference (Sect. 2.3). To live up to its name, the point of this theory must be to

find out which earlier, internalized relationship is revived and transferred to the analyst. We therefore speak of father, mother, and sibling transference and mean the actualization of the conflicts and/or unsatisfied wishes and needs that are associated with the prototypical images of these persons and that have become a "cliché" in the sense that Freud used the term.

It would be possible to achieve a slightly different focus by correlating the particular contents of the transference to typical forms of anxiety; the context of the momentary genesis of the latter would of course have to be taken into consideration. In order to be able to comprehend a patient's anxieties both in and outside of transference it is necessary to be familiar with the psychoanalytic theory of anxiety, which we outline in Sect. 9.1.

Examples of the connection between present and past in therapeutic technique are distributed throughout the entire book since movement back and forth along the temporal axis forms the basis of all transference interpretations. For a theoretical introduction we recommend reading Sect. 8.4 in Vol.1, and believe that our examples can help steer the ongoing controversy about transference interpretations that refer to the present and those that refer to the past into more productive directions. The question of how *retrospective* ("then and there") transference interpretations and transference interpretations referring to its *actual* genesis ("here and now") can be combined or supplement one another in order to be therapeutically effective in an individual case is obviously an empirical matter. We introduce this distinction in order to have descriptive adjectives at our disposal, yet it also emphasizes the link between present and past, which led via the observation of repetition to the psychoanalytic theory of transference. The two adjectives "retrospective" and "actual" are not usually employed in the psychoanalytic literature, and it is therefore appropriate that we justify introducing them. Transference interpretations directed to the here and now have required that the analyst provide a circumstantial description indicating that he is hinting at a connection to himself or to the psychoanalytic situation or that he is starting from the manifest level. Actual genesis does not specify the depth to which present experiences are anchored in the past. One consequence of this is that interpretations of the actual

development cannot simply be patterned after the stereotype that probably goes back to Groddeck (1977) and is associated with the sentence, "You now mean me" (see Ferenczi 1926, p. 109). We discuss this topic in detail in the introduction to Chap. 4.

What we refer to as retrospective transference interpretations are familiar to the reader under the designation "genetic interpretations." What justification is there for the new term if we adhere to Occam's old dictum, *Entia non sunt multiplicanda praeter necessitate*? Although we hesitate to further increase the number of psychoanalytic concepts, it is nonetheless useful to introduce the term "*retrospective* transference interpretation"; it is only slightly burdened theoretically, whereas genetic transference interpretations imply the reconstruction of the psychogenesis and claim to be able to explain present behavior and experience with reference to their causes. To look back to predecessors is far less ambitious than to trace certain transferences back to causes in childhood. Retrospective transference interpretations take the principle of retrodictive attribution (*Nachträglichkeit*) seriously (see Sect. 3.3; Thomä and Cheshire 1991).

Hardly any topic stirs feelings to the degree that the debate over the different transference interpretations does. Although this controversy also has to do with therapeutic effectiveness, the bitter polemics seem, as far as they are not motivated by professional politics, to result from differences regarding the psychoanalytic method (Fisher 1987). Gill's (1984) social conception of transference has, if we disregard a few exaggerations that he himself has conceded, the following implications. We must proceed from the fact that influencing is an element of every human interaction. Transference interpretations are, accordingly, two-sided; they act within the sphere of (mutual) influence and take it to a *new* level.

In order to enable the analyst to interpret transference—regardless of the specific contents and forms and regardless of which type of interpretation is preferred—within the helping alliance, it is essential that he not transgress certain limits placed on interaction. This salamonic

view taken by Gill (1984) is approved by all sides because the psychoanalytic method obviously requires a framework. We refer the reader to our discussion of the function of rules in Chap.7 of Vol.1.

The reader has the opportunity to retrace, and in a certain sense even to reexamine, our protocols and transcripts of treatment from the perspective of transference interpretation. He will surely find numerous weaknesses that the analyst is responsible for or that we have overlooked. In today's psycho boom there are more than enough repulsive examples of such transgressions that make therapeutically effective interpretations of transference impossible and that should be considered as malpractice. We do not want to contribute anything to them.

Yet where are the differences—which usually escape notice—in the controversy over actual genetic and retrospective transference interpretations, and which Sandler and Sandler (1984), as helpers in a time of emergency, believed they could resolve by introducing the new concept "present unconscious"? According to this concept, transference interpretations emphasizing actual genesis would be directed toward the present unconscious, and the familiar, traditional division into different layers of the unconscious would be extended by a conceptual innovation. Disregarding a few rather terminological finesses, the actual differences between the preconscious and the present unconscious are minor. Gill's passionate argument in favor of transference interpretations of actual genesis is in fact primarily directed at the patient's preconscious perceptions, and he recommends proceeding from their plausibility:

> It is not merely that both patient and analyst contribute to the *relationship* but that both contribute to the *transference* . Furthermore, the social conception of transference is based on a relativistic view of interpersonal reality in contrast to the usual absolutistic one. Transference is not only always contributed to by both participants, but each participant also has a valid, albeit different, perspective on it. Hoffman and I have argued for the rejection of the usual psychoanalytic view that one can dichotomize interpersonal experience in general, and experience in the analytic situation in particular, into veridical and distorted. We see interpersonal experience, instead, as always having a degree of plausibility. (Gill 1984, p. 499)

This rigorous social conception of transference, also pleaded by Stolorow and Lachmann (1984/85), demands that the analyst reflect on his theories of reality and relativize them with regard to the patient. The emphasis put on plausibility is directed against the *dichotomy* of real or realistic experience on the one hand and distorted experience (as the traditional definition of transference) on the other. As a consequence the alleged distortion, i.e., the deviation from a realistic perception of reality, cannot be precisely defined either. Such distortions of perception therefore cover a wide spectrum. The consequences of this point of view for our understanding of transference interpretations are very far-reaching. It is up to the *two participants* to deal with the "cues: the perceptual edge of the transference" (Smith 1990). The task is easy if a patient himself classifies a perception, experience, or manner of behavior as fairly abnormal and the analyst agrees, so that each can start the study with his own tasks, in order to achieve the goal of change desired by the patient. Therapeutically the point is obviously not to conduct an abstract discussion about where the borders of normality are, and also not to continuously discuss differences of opinion in order to overcome them. We simply want to emphasize that it is up to the two participants, the patient and the analyst, to clarify where reality might be distorted in the psychoanalytic situation. Furthermore, the patient and the analyst do not live alone in a world of their own but in a multilayered sociocultural reality in which some average values apply although they lack normative force for the individual's private life. The patient's and analyst's intersubjective determination of a continuum is thus interconnected with the opinions they share with their respective environments.

Associated with the social point of view is the recognition that the analyst exerts a very strong personal influence on the patient, a fact which was also emphasized by Freud when he, while discussing the technique of suggestion, referred to the word's literal meaning. Yet Freud also undertook the vain attempt to use the set of psychoanalytic rules to obtain uncontaminated data. His understanding of the resolution of transference was to attempt to undermine the suggestive force of powerful figures in childhood and their revival in analysis. This orientation toward the *past* has contributed to our neglecting the large influence the analyst has on the

present and the actual genesis of all psychic manifestations, including symptoms. The solution of the clinical and scientific problems of psychoanalysis requires first of all that we proceed from the fact that the analyst's influence poses an inevitable contamination of the observed phenomena. This means that it is necessary for all psychoanalytic data to be examined with regard to the analyst's contribution (Meissner 1989; Colby and Stoller 1989).

2.1 Therapeutic Alliance and Transference Neurosis

2.1.1 Promoting the Helping Alliance

In the introductory phase the analyst can make a substantial contribution toward helping the patient quickly come to terms with the unfamiliar situation. Creating hopes at the very beginning and being helpful in developing unused abilities are not the same as promoting dependence and illusions by means of crude suggestion. The growth of the therapeutic alliance and the development of transference can strengthen each other. If the "helping alliance" (Luborsky 1984) is fostered, both the "working alliance" (Greenson 1967) and transference thrive. It is then possible at an early stage to show the patient the neurotic conditions of his behavior and experiencing and, above all, the capacity for change that remains despite all limitations.

In the initial interviews Erna X told me that she suffered from numerous neurotic symptoms and, since childhood, from neurodermatitis. I was recommended to her by friends of hers. She had informed herself about her illness by reading books. Judging from the external and internal conditions it was possible to proceed directly from the interviews to therapy. I formulated the basic rule in accordance with the recommendation made in Vol.1: "Please try to say everything that is on your mind or that you think and feel; it makes the therapy easier."

Erna X began by describing a conflict that had existed for a long time and that she had already mentioned in the initial interviews, namely her indecisive attitude toward a fourth pregnancy. On the one hand, she very much wanted another child, on the other there were numerous objections. In the period since the initial interview she had had a routine

examination, and she had seen the wrinkles on her gynecologist's forehead as she had mentioned her desire to have a fourth child. She mentioned her mixed feelings. In response to his question of how she would decide emotionally, she had said her emotions said definitely yes, but her intellect said no.

A: I have the impression that you're torn back and forth. You want to leave it up to chance in order to avoid having to make a decision.

Commentary. This statement implies the tendency of not leaving the decision to chance.

P: At the present I'm entirely prepared for a fourth child. When I go window shopping, it makes me happy to think about being able to buy things for a new baby. But with four children I would have to stop working. Physically I wouldn't be able to take it any more.

Erna X described something similar regarding an allergy test. It had taken her entire courage to interrupt the examination after she had had to wait for hours and hours. She complained about the doctors' lack of willingness to provide information. The examination was supposed to have been repeated three more times, but she couldn't sacrifice a whole afternoon each time. The patient was pleased by her courage: "Courage turned into anger. Being angry, I was able to be courageous."

The patient spoke about her punctuality and about her bad conscience at leaving her children alone. A central theme was that the patient got into situations in which she was in a hurry and that with increasing stress her skin symptoms were joined by situative increases in her blood pressure.

I created an analogy to the session: she was feeling increasingly stressed because of the appointment. The patient emphasized the difference: she expected something from therapy, but nothing from the test.

Erna X talked about her extreme anxiety about blushing: "I often turn dark red, down to the roots of my hair." I made the more precise statement that she apparently suffered from shame

anxiety. The patient confirmed that she knew it. She said she was ashamed of everything that had to do with sexuality: "I turn red as soon as I think of my anxiety."

The patient's anxiety about her insecurity triggered her symptoms and led in a typical way to its secondary reinforcement. I made the interpretation that all the feelings were lacking that had originally motivated her blushing and anxiety, and said that it was therefore important to determine which themes underlay her shame anxiety.

Erna X then said that the subject of sexuality had not been talked about at home; sex had never been explained to her. She was uncertain whether she was supposed to laugh or not when a joke was told. She described a shameful situation in which she had been sitting in front of the apprentices at work and turned dark red. She had got mad at herself, exclaiming "Am I stupid!" Her anxiety about blushing was especially strong at work. I returned to the fact that she would be at home more if she had a fourth child and that there would be less of a burden on her.

During her pregnancies she had felt well. Even her skin had been very good after the first one, and she had only taken a little cortisone. She compared her youth to today's 15- to 16-year-old girls who are carefree, and said "Were we dumb!" I described her condition with regard to her other problems: always having to run around with a bad conscience was creating increasing restrictions. The patient noted that for years she had prayed that her parents would not find out anything about her tricks. What other people thought played a decisive role at home. At the moment her mother's biggest worry was that somebody could find out that she was going to a analyst.

It seemed natural to interpret her own worries as an internalization of her mother's values and to make an indirect attempt to support her independence. The question was raised of how far the patient kept her own views to herself in order to please her mother. In contrast to her mother she had a positive attitude toward therapy, which she said had already helped: "I like to lie down. On the way here I thought, `Am I happy when I can relax.'" She said she was not able to organize her time any better. I asked her about her work schedule, and she described how she

put pressure on herself by believing that she always had to do more and more. We talked about her difficulty to adjust and to change a plan, i.e., the compulsiveness of her planning. Her reaction was: "Then everything will fall to pieces and my skin problem will come back right away."

We then considered the real possibilities of her finding household help. Erna X had already looked around. She had a bad conscience toward her children. Now she had to get through a few more weeks, and she wondered whether her neighbor might not be able to help her out. The question of paying the neighbor came up, and in this context we spoke about her family's finances. She had numerous differences of opinion with her husband, and his criticism made her feel very insecure.

It became apparent that she took criticism very seriously. In the course of her marriage Erna X had become even more insecure and self-critical. The fact that her husband considered this entire situation *her* problem annoyed her, and she was happy that she could talk about it here. It was obvious that Erna X was looking for support against her husband's arguments.

I broke a longer period of silence by asking if she was irritated by the silence? Was she waiting for something to happen? She said that she was being considerate and just waiting before continuing although her thoughts had already gone further.

I now made it clear that I would say something on my own if I thought I could contribute something in a given moment. I encouraged the patient to freely say everything that came to her. I then raised the question of whether she had the impression in other aspects of life that she talked too much and did not let the others get a word in. In private conversations, she said, she was rather restrained, an allusion to the distinction between "in here" and "out there," i.e., between the analytic situation and life in general.

Whenever she was waiting for her husband she would think about everything that had happened during the day. Yet if he called to say that he would be late, then everything was over, and when he came on time, he usually did not want to talk. Sometimes she said something anyway, but did not get through to him. It was very unusual for a conversation to be

satisfactory if one did develop. She would sometimes call a girl friend to pour out her heart. She was surprised that she so successfully managed to speak freely in the analysis.

The difference between in here and out there was discussed further. I noted that in life we sometimes get answers or that sometimes questions are raised, whereas in analysis I would sometimes not pick up a theme. We considered whether the patient might be disappointed if I did not and remained silent instead.

We went on to discuss the sense in which the fundamental rule provided support. Following it, some aspects of our dialogue would seem unusual and might therefore make her feel insecure, because they are not customary. I emphasized that it was not my intention to make her feel insecure but that this could be an unintentional side effect. This made it clearer to Erna X that she could continue if a pause occurred.

She got caught up on the word "insecurity" and remarked that she continued our talks by herself after the hour was over. For example, after the last session she continued thinking about the subject of adjustment. Because of her insecurity and although she knew better, she would call her husband when she had difficulty making a decision.

P: I shy away from making decisions on my own about very banal matters. It's another aspect of my exaggerated adjustment to my mother.

A: Is this part of the idea that the good Lord knows everything anyway?

P: Yes, I was always possessed by the thought that my mother would hear about it after all, that she would find out sooner or later, and naturally that is how it often turned out. In fact, it often turned out that she was right.

Her husband criticized her because she always turned to her mother. Yet he was frequently not available, and this was *her* criticism of *him*. Erna X emphasized her tendency to follow her mother, with very few exceptions.

Her son Jacob learned bad expressions at kindergarten, and her mother was horrified when

she heard them. Erna X said that she would have been spanked if she had done something similar. She defended her children against her mother's moralistic manner. The patient was able, via her identification with her children, to express her right to independence.

Commentary. This early session was chosen for prescriptive reasons, because we believe that it displays an exemplary mixture of the different elements constituting the structure of a helping alliance.

2.1.2 Support and Interpretation

In the following example we want to show that interpretations per se can have a supportive effect. The supportive aspect of the psychoanalytic technique is especially strong when interpretations are given in a manner that wakens the patient's hopes of being able to master his difficulties. The establishment of a helping alliance by means of an analysis of transference takes place in the context of interpretations. Particularly in the initial phase, the goal is to create a basis of trust. Although it is necessary to distinguish between the various therapeutic elements and their distribution or mixture in different types of technique (e.g., psychoanalysis, expressive or supportive psychotherapy; Wallerstein 1986), we emphasize here the supportive aspects of psychoanalytic interpretations in their own right.

Daniel Y had suffered for years from numerous neurotic anxieties and hypochondriac fears. He was particularly tormented by his fear of becoming insane. For several reasons it was very difficult for him to decide to undergo therapy. He had also obtained information about behavior therapy. Yet since he not only suffered from his symptoms, but also felt cut off from his life history and was unable to remember hardly anything prior to puberty, he believed that he required psychoanalytic help. Daniel Y's suffering from his anxiety attacks and from the feeling of being separated from his personal roots was so severe that he put aside all his reservations against psychoanalysis.

He was very surprised at the course the treatment had taken. He had neither encountered a silent psychoanalyst nor suffered a worsening of his symptoms, something he had feared the

most. He had heard and even observed among his own friends that negative fluctuations initially occur in psychoanalyses and that it was only after having passed through many transitional phases and after resolving conflicts that an improvement might occasionally occur. That I did not leave it to Daniel Y to hold monologues, but made comments that offered him support was in positive contrast to his expectations. In doing this I followed the therapeutic principle of creating the best possible conditions for *mastering* earlier traumas that had been passively incurred. This therapeutic approach made it easier for the patient to verbalize for the first time his despairing helplessness with regard to overpowering impressions made on him in the present and past and to do something about it. Both the patient and I myself were touched by the intensity of his affects, particularly his crying. My unswerving calmness helped him keep his feeling of shame about his childhood experiences, which were in such complete contrast to his successful career, in limits.

Overall a good balance between regressive immersion into affective experience and reflective dialogue had developed in therapy.

Daniel Y's panic attacks, which occurred especially in small rooms, had turned his frequent and routine business trips into a torture, regardless of whether they were by car, train, or airplane. He was surprised that he felt considerably better after only a few weeks and had already been able to manage several long trips by car without any anxiety. I saw one reason for this improvement in the fact that the patient had acquired some confidence and consequently hope. In this sense the improvement could be considered a transference cure in the wider sense of the word. Another reason was that the patient had already been frequently able to experience that, although his helplessness and powerlessness recurred, he was by no means passive and helpless toward all the strain he experienced, and that he in fact was able to actively confront his old, conserved traumas and whatever triggered them in the present. Thus the improvement could also be attributed to the analysis of conflicts.

There had been no reason for me to make the patient aware of my assumptions about these two aspects of therapy. Then Daniel Y had to go on a week-long overseas trip that made him feel apprehensive since he had not flown in the last few years without experiencing a panic

attack. In view of the planned flight I decided to make an explanatory comment, which I expected to have a settling effect. I reminded the patient that he had already successfully gone on numerous trips by car and train because he no longer felt at the mercy of things beyond his control and had obviously regained his capacity to assert himself. My intention was to make the patient aware of this enlarged sphere of action and to reinforce his own self-confidence. The patient was moved by my statement. We were hardly able to talk any more because of his sudden and intense outburst of crying. In view of the experience that it is rather unfavorable to conclude a session leaving a strong affect undiscussed, I was not entirely happy when he left. Yet I also had the impression that Daniel Y had gained self-assurance and could therefore handle his emotions.

Daniel Y came back in the best of moods. He had not, against all his expectations, experienced any anxiety during either of the flights. Since he was familiar with psychoanalytic rules from hearsay, he had in the meantime wondered whether my support was permissible. At the same time the patient was amazed that I had undertaken such a venture and taken the risk of making a kind of prediction. He wondered, furthermore, whether his confidence in my ability would not have suffered seriously if he had had a relapse. I now tried to explain to the patient that I had taken a calculated risk and thus had not acted arbitrarily or made a chance suggestion. Daniel Y had in fact forgotten that I had grounded my assumption that he *might* be able to travel free of anxiety in a reference to his increased self-assurance.

This patient, who was a successful scientist, became increasingly interested in learning more about the curative factors. In a later session we had an exchange of thoughts that again ended in a violent affective outburst, which I will now describe.

Daniel Y was disturbed that he was not able, despite his intelligence, to grasp the reasons for the extent he had become free of anxiety. It was an obvious wish of his to learn something about the conditions of his improvement. It was his approach, as he practiced in his profession, to gain assurance—or correct mistakes—by learning the causes of something. The patient seemed relieved that I considered his curiosity about which factors are of consequence therapeutically as something natural and that I said it was his good right to know. He had

expected me to skip over the implicit question or simply reject it. He suddenly became very aroused and anxious. I was now able to explain to him the momentary manifestation of anxiety. He had wanted to know more from me but had been afraid to come any closer. He was very ambivalent, hoping that I was not groping in the dark, but also envying me because of my knowledge and the calm manner in which I took his comment about being afraid that I was perhaps really just stumbling around in the dark.

The inequality between us and the fact that I knew so much about him reminded him of his childhood feelings of powerlessness and being excluded. Daniel Y was encouraged by the fact that I made a few comments about the genesis of his anxiety and did not belittle the intensity of his feelings. Suddenly the patient was overcome by an outburst of hate against an "uncle," who had taken his father's place and whom, at his mother's behest, he had had to obey. He was severely shaken by the intensity of his hate and the anxiety associated with it, and convinced by my references to the connections to his experiencing during the session. From his restrained criticism of me and my reaction to it, the patient thus gained sufficient self-assurance to be able to deal with his strong affects.

The oedipal source of tension had now become so immediate that the conditions were favorable for attempting to revise it. It is noteworthy that although at that time he had won against his "uncle"—his other's lover after her divorce—he nonetheless had retained a deep feeling of inability, even of having a physical defect and hypochondriac anxieties that centered on his heart. Somewhat later he was able to overcome his shame and say that until the late assertion of his sexuality he had felt very depressed about never having ejaculated during masturbation. His anxiety about his pleasurable oedipal aggressions had resulted in inhibition and a functional disturbance that accompanied it. This, in turn, had strengthened his feeling of inferiority despite all his successes in professional matters.

2.1.3 Common Ground and Independence

Gill and Hoffman's (1982) systematic studies have made us aware of the significance of actual cues in transference. Their suggestion is that we should proceed from the plausibility of the

patient's perceptions. It often suffices to acknowledge that an observation regarding the analyst or his office is plausible. Frequently, however, a further-reaching explanation is required which cannot be related only to the patient's fantasies. We have dealt with the general problems of treatment technique in this regard in Sects. 2.7 and 8.4 in Vol.1. The following example illustrates the corresponding steps in technique.

We refer to an exchange of thoughts in the 61st and 62nd sessions in the analysis of Arthur Y and occasionally quote from it, in order to show what it means to acknowledge actual truths in the here and now. The metaphors used by the patient are especially well suited to characterize his mood.

The two sessions preceded a longer vacation break. The topic was the patient's curiosity; in my interpretations I had indirectly encouraged him to be more curious. My encouragement led the patient to remember having suppressed his curiosity toward me on an earlier occasion. "At the time I didn't dare ask, and even today it's not easy for me," and the patient immediately said what the reason was, "I wouldn't have received an answer from my previous therapist, just the counterquestion, `Yes, why does it interest you?' And after you have been asked such counterquestions often enough, you don't feel like asking any more."

Arthur Y was interested in knowing where I was spending my vacation. On an earlier occasion I had given him my address.

Arthur Y talked about a large and well-known ski run, which I am also familiar with. He did not restrict his curiosity and risked asking the question he had previously avoided. Decisive was that I gave him an evasive answer, leaving open whether I had already gone down this ski run. I only made a general, noncommittal statement, "Everybody in Ulm knows this part of the Alps, those mountains in Allgäu."

It was not until the next session that the consequences of my refusal became clear and, what is more important, could be corrected. At first Arthur Y had seemed to be entirely satisfied with my answer, but his momentary subliminal frustration was reflected in the examples he

mentioned from his previous therapies. He recalled an important metaphor: the image of a snail that puts out its feelers; you only have to touch the feelers and it withdraws into her shell. "I acted in just the same way with them [the other therapists]." And then he recalled, at the opposite extreme to the snail, a large dog showing its teeth. "You don't go around touching him, otherwise he might bite your finger off."

It seemed obvious that the patient was describing himself as the snail and the analyst as the vicious dog that should not be provoked by asking questions. The patient corrected this assumption in the next session. In the first third of it a good atmosphere was created because I was able to calm him; he had anxieties because of the issue of discretion—information passed on to the insurance company etc. The patient now had sufficient assurance to again return to specific points. In connection with the dog, he complained, "If I had only once been the dog and barked . . . ." I mentioned the consideration that, according to this comment, he was not bitten, but bites. He admitted that my opinion was not entirely wrong. After disarming the criticism in this way and putting me in a friendly mood, so to speak, he remembered the rejection he experienced from my evasive generalization regarding the ski run. He experienced my evasiveness, as he said, as a red light—"Better not ask any further"—whereupon I made an allusion to finger, bite, the object's rage, and retreat (the snail). The patient made it clear that for him such an inner retreat was a defeat that provoked revengeful feelings.

I confirmed that I had been evasive and that this had altered the relationship between the snail and dog at the expense of intense curiosity. My interpretation was, "It's true that I was evasive. I did not say that I know the ski run, but generalized. Perhaps you experienced this as a strong rejection because you were not only curious, but because intrusiveness is linked to curiosity—the vicious dog." Thus, I did not say, "You were afraid of hurting me then," as if he had only imagined this anxiety

and I had not been irritated. I instead acknowledged the *plausibility* of his perceptions. Such acknowledgment probably leads to a corrective emotional experience by letting patients test in the next few steps they take whether they remain welcome with their recently acquired new patterns of thought and action.

I later—after explicitly answering his direct question about the ski run—commented that it can sometimes make sense not to answer a question immediately. Responding to my explanation, the patient summarized, "Yes, if you answer questions immediately, the thought process may stop prematurely." The patient thus confirmed that it sometimes makes sense to leave questions open in order not to terminate the thought process.

Upon closer examination of his choice of words, it turned out that he attributed the analyst a cunning form of behavior that he knew from himself and that he sometimes employed to reach goals or just to make ends meet, according to the saying that the end justifies the means.

The patient's curiosity had now become more intense, after we had previously used associations to establish multifaceted connections to words such as "drill" and "penetrate." The patient remembered, "People say, `He's drilling me with questions.'" We talked about the upcoming vacation break. Arthur Y knew that it would not be easy to reach me, which provoked him into being *penetratingly curious*. We reached a compromise that did justice to the different aspects of the technical problem. On the one hand I did not say where I would be staying, and on the other I assured him that in an emergency he could reach me through my office.

In view of the vacation break, it was important to me at the end of the session to emphasize the things we had in common. Since we were familiar with the same region, I used metaphors such as that we are already on good footing.

The acknowledgment of actual truths acquires special significance in situations where the helping relationship is put to a special test, for example by an interruption for a vacation. The analyst should handle questions in a manner that provides the patient both satisfactory answers and the assurance he requires for the period of the separation. Our stance can generally be characterized by the phrase, "As much common ground as necessary, as much independence as possible."

The course of the sessions discussed here makes it clear that the therapeutic process can facilitate the correction of the side effects of analytic interventions, since, obviously, in addition

to favorable effects, interventions can have unintended negative side effects that may not be immediately visible.

2.2 Positive and Negative Transference

The spectrum of positive transference is very wide, ranging from mild forms of sympathy and esteem to ardent love. One speaks of eroticized transference if it reaches such a degree that it constitutes a lasting obstacle to the working alliance. Transference love often turns into hate. Negative aggressive transference can therefore often be understood as the consequence of an experience of being rejected. The following examples illustrate this spectrum.

2.2.1 Mild Positive Transference

The patient Erna X came to talk about Tilmann Moser's autobiographical account *Lehrjahre auf der Couch* (My Apprenticeship on the Couch), in which he described his strong and aggressive attacks on his analyst (see also Chap.7). She had previously thought it inconceivable that she could become so infuriated. In the meantime she had become skeptical about the absence of negative affects in view of an approaching interruption in treatment, which she was disappointed at.

P: Well, I was unhappy that you didn't tell me where you're going on vacation. But I said to myself that I didn't have a right to know and that you certainly knew what you should tell me or not.

I assumed that the patient suspected that an answer was being withheld from her in order to make her mad. It would then have been consistent for her not to let herself be provoked or manipulated any more. I pointed out that this might be the first sign of a struggle for power or that one might be implied by this topic. I denied having any manipulative intent in not telling her something.

Erna X emphasized that she had not imagined that I wanted to make her angry. She

thought that I wanted to do something to make her think, which I confirmed.

The patient added more to this theme and in the dialogue extended and deepened it. At first Erna X was concerned with my 3-week absence. Her ambivalence was connected with two opposing chains of motivation. On the one hand she expected a rigorous professional sense of duty and selfless effort. On the other hand she was looking for a role model in order to transform her life with her husband. In her opinion it was probably fairly hopeless to expect her husband to delegate some of his business obligations and to show more interest in family life and vacation. If I were really to go on vacation for 3 weeks, I would correspond to her ideal. As much as she herself wanted this lifestyle, she was just as afraid that further complications might result from the discrepancy between this ideal and her reality. This was probably the reason that she held tight to the idea that I was not going on vacation.

After some silence the patient related a dream about me.

P: In the second dream I was lying with you on a couch, not here, but in another room. The couch was much larger. I can't remember any details, just a feeling, namely the feeling of security. There was also a feeling of pride and amazement that you allowed it, that you allowed me this intimate closeness, that you didn't run away or shove me away. A telephone call disrupted us. Now it was a room like your office after all. It was a call from a woman, who said that you should pick up your car at the garage. I wanted to know which woman had called. You didn't answer. I thought it was your mother or another woman. Then we went through town together.

It's difficult to describe the feeling that you have in a dream. I was somehow completely at ease with you. When I am here, then I always think that I have to do everything right. In the dream everything was different.

A: Yes, in a dream you can take all the liberties you want.

P: Most of all I would have liked to call you right the next morning. After waking up, I thought about it and was pleased. At first I had the thought, no, I can't tell you that I dreamed we

were on the couch together. On the other hand, I didn't dare to not tell you about the dream. Otherwise I like to talk with you about dreams.

A: You were worried because of the intimacy in the dream.

P: Yes, I was embarrassed.

I then referred to natural human desires and emphasized that hers were stimulated by our talks.

A: It's natural for you to include me in your world of dreams and wishes, just as you do other people with whom you discuss personal things.

The patient had had similar thoughts before the session began. I now drew attention to the other woman's intervention.

P: Yes, it was jealousy. Yes, this other woman took you away from me.

I reminded the patient of an earlier dream.

P: Yes, in the dream you cancelled a session. Your car turns up over and over again. Yes, even in the dream you came in the car to visit me. An important factor in my choice of a friend was the fact that he had a big car. That must be the reason that the car plays a special role. We went down the street downtown almost dancing. Why shouldn't I admit to having this desire? But I can't tell my husband this dream.

A: The question is whether you can awaken your husband's understanding for the subject of the dream, namely your desire for more gentleness.

I intentionally used the word "desire," which implies all kinds of erotic feelings, pointing out that therapy wakens more desires and that it would not be simple for her to transform her life and to get her husband's support for doing so. Her husband was involved in his family in a way that was comparable to how she was linked to her parents.

The patient wondered why she had thought of me and not her husband.

A: Probably because you speak with me about it more than with your husband.

I interpreted that the patient was seeking relief via her question.

P: Yes, I could have answered the question myself, but I don't know how things can continue. Yes, I don't want to accept the fact that you meet my wishes in every respect. The feeling of being understood and of security that I had in the dream, I will never have this feeling toward my husband. I have been married long enough that I can predict my husband's reactions. The fact is that I stand there alone and he doesn't help me.

The patient mentioned an example from her everyday activities with her children to show her husband's lack of willingness to help take care of the children.

P: And that's the way it is at home. If I defend myself against my mother and refuse to take on another task, then she gets indignant and complains about my useless and time-consuming therapy.

A few days later the patient's desire for a baby became more intense. Although all reasonable considerations still spoke against it, and although she just recently, at a gynecological consultation, was relieved to hear that she had had only imagined she was pregnant, she still wanted a fourth child. Concerned about the ambivalent nature of her attitude, she tried to clarify her thoughts in the sessions.

In order to make the following interpretation of her desire for a baby more comprehensible to the reader, I must summarize a vivid description the patient gave of children playing, both her own and other boys and girls from the neighborhood. With disbelieving surprise she had noticed the carefree and natural way the 3- to 5-year-olds acted, who made no secret of their pleasure in showing themselves and in touching and looking. In these children's sexual games one of the boys showed his penis, which triggered reactions of penis envy in one girl. This girl held a large crocodile where her penis would be and said it would gobble up the boy, who had already developed a phobia. This girl triumphantly used the crocodile—as a much larger penis—to frighten the boy. It was only with great effort that the patient was able to let the children go

on until they, on their own, had satisfied their curiosity and their interests had turned to something else. It would have been more natural for her, like her mother, to intervene and forbid such games, or, like her grandmother, to distract them by telling them about something more beautiful or decent. The patient had drawn conclusions about how her mother probably had acted toward her during her own childhood from the educational measures her mother used toward her children during visits. She was infuriated to observe how her mother made up stories to avoid answering important questions.

Although she knew that having a fourth child would substantially increase the burdens on her and that she would not be able to count on any support from her husband, she was nonetheless filled by a deep feeling of happiness when she thought of the moments of closeness and intimate contact during nursing. Her wish receded completely when she felt understood and when she continued our dialogue by herself after a good hour. Her very busy husband had hardly any time for her, and their sexual relations were unsatisfactory and so infrequent that it was improbable that conception would take place.

Erna X was strongly moved and reflected briefly before responding to my interpretation that she wanted another child in order to repeat her own development under more favorable conditions. I interpreted her further associations that she never had the wish for another pregnancy during the sessions as an expression of her satisfaction at feeling understood, and not as a defense against oedipal wishes.

My interpretation, which I intentionally couched in very general terms, that she was seeking her own unlived life in another child fell on fertile ground and precipitated a wealth of ideas. The patient assumed that the function of her desire for another child was to help her avoid restructuring her everyday life at home and work. The restrictions that a fourth child would impose on her would make most of the professional things impossible that she now—freed of some neurotic inhibitions—felt confident enough to attempt. She told me about a dream that was triggered by the children's games and by my previous interpretations. In it she saw a number of photographs of *me* in various shots on the beach of a lake.

Her sexual curiosity had been stimulated in transference. She herself had been in embarrassing situations at a beach. As a girl she had been laughed out because she wore a padded bra in a bathing suit that was much too large. Although she had caught her uncle's eye, he acted as if he was not at all interested in her.

Finally I interpreted her unconscious wish to have a child with me and from me. She said that this made sense to her although she had never consciously had such a wish. Now I referred to a statement by her uncle that he did like to *make* children even though he did not want to have anything to do with them otherwise.

The topics changed over the next few sessions. Other aspects of this focus became visible. Referring to the last session, the patient remarked that it was easy to start today. She could not forget something I had said in the last session: "Today you are not in the same situation as you were then as a child. Today you have something to offer."

P: What do I have to offer? I am not ugly, and I am not dumb. I sometimes think I am too demanding. I'm never satisfied. But then I also asked myself why you told me this toward the end of the last session? Was I lost? Did you want to give me moral support? Tell me what I have to offer.

A: I didn't say it to give you moral support, although that is one aspect. I wanted to refer to the fact that you are no longer as helpless and ashamed as you were as a child. That you don't have any more associations and ask me seems to me less a consequence of your increased demands than a phenomenon accompanying the fact that you are disturbed here by your spontaneity and associations.

P: That is just how I feel, ashamed and helpless and padded. Today I am almost the same as then. But after the last session I was satisfied.

The course of this exchange differed from that on the beach. The patient told me that she was thinking about the meaning of the words "helpless," "ashamed," and "padded." After a long silence, I encouraged her to tell me her thoughts.

P: It's difficult. I sometimes feel terribly helpless. Then my condition is just the opposite. It's the extremes, the middle is missing. Just like after the last session. I left and was exceptionally pleased, but as I got to my car I had the thought, "Just don't imagine anything; it was probably just a move to give you some self-confidence."

A: And therefore not sincere.

P: Yes, sincere, but with the ulterior motive of helping me.

A: What is wrong with this helpful ulterior motive that makes you aware of something? There is an ulterior motive involved, namely that you can use your body. From time immemorial you have thought that you don't have anything. Today you have something that you can show. [The patient suffers from a fear of blushing.]

P: Yes, but it's nothing I have achieved. It's a stage of development. It came all by itself. I didn't earn it, and then it is obviously nothing for me. [Long pause] I wonder why it is so difficult for me to believe that I have something to offer.

A: Because then you would think about something that is forbidden, and that could have specific consequences, for example, that you could be more seductive than you are supposed to be. And that your uncle then would make or have made even more advances.

P: But who tells me how I could be?

I implied that the patient was so much under outside control as a result of her upbringing that she was not able to test her own sphere of action. Everything was clear when her mother decided what was to be done. At the same time she saw in her own children how pleasing it was for them to try to do something when she left them scope for acting on their own.

P: The whole affair refers to something emotional as well as something physical. I'm insecure in both. Yes, it's part of the nature of thinking and feeling that there are always other sides to things. There is security as long as something is completely determined. When there is more openness, then there are also more ulterior motives.

Thus the fact that I had ulterior motives disturbed the patient.

P: I often believe you have ulterior motives because you're thinking about something and have a goal.

I emphasized that while this was true, it was also possible to speak about it. The patient, in contrast, assumed that you cannot speak about it. Erna X emphasized that she actually did not dare asking about it. She admitted that she sometimes liked to be guided, but added that if you did not take the chance to ask, then you risked the danger of being manipulated, something she certainly did not want. It was nice to let yourself be guided, but on the other hand it was disagreeable.

A: But if you can't know about all of this and can't ask, then you can be manipulated. You have been pushed around and influenced a lot. You would like to have something that suits your needs, and it can't be achieved without more reflection or questioning.

P: Because I don't want to be obtrusive and to ask stupid questions, your ulterior motives remain unclear, but I naturally often wonder what your intentions are. This was especially strong in the last session, because I really would like to offer you something and yet am immensely insecure. The word "padded" moved me very deeply. People think of something that I don't have at all, just like in that moment of undressing on the beach. With the uncovering comes the shame, and I turn red, and the helplessness comes. There are exactly three stages, not from helplessness to being ashamed to being padded, but the opposite.

I confirmed that the sequence appeared to be the one the patient described. Material things were agreeable, and money and a nice car were important to the patient. I reminded her that she had had too little to show at that traumatic experience. She had been padded with something artificial.

P: I can see the image of a balloon, and when you poke it, everything is gone. Yes, that's the exact sequence: padded, ashamed, and helpless. That's exactly the situation in which I turn red. Yet behind the padding there is a lot of life.

A: Yes, it was there too. The bra was padded, but behind it there was something. A nipple, a growing breast, your knowledge of growth from the sensations in your own body and from the comparison with other women.

P: But it wasn't enough, and it was too small, and I was dissatisfied. Nobody told me that my breasts would get larger. It's more likely someone would have said, "Well, what do you want at your age. You're still a child." I couldn't talk with anyone about it. I was on my own. True, I did learn some things because my mother forced me to do them. She gave me exact instructions, and it worked. Commands were given. I had to do something and to learn it by heart, such as going to a government office. But it was more my mother's action than my own. I didn't have a choice. I was forced, and it wasn't really me, and that is probably why I don't have the feeling that I got any further. It's between the extremes—"I can't do anything at all, I can do a lot"—that the middle part of my own doing is missing.

I referred once again to the ulterior motives. Which hidden thoughts were guiding her?

A: You suspected that something was being planned again. Something was being manipulated, and it was very serious because you weren't informed. This is the reason that you were shy to ask what I meant. You followed the reasoning, "They are only thinking of my own good. Then I don't have to ask."

P: I was used. I wasn't told, "Please do it. I don't have any time." No, it was arranged; you do it, there's no alternative, and then I felt the ulterior motives without daring to ask anything. It was dishonest. I knew about the dishonesty but wasn't able to talk about it.

Commentary. The encouraging interpretation of the patient's reluctance in transference had a positive influence on the cooperation. Such observations are exceptionally important for evaluating the therapeutic process.

2.2.2 Strong Positive Transference

Strong positive transference remains within the framework of the working alliance, in contrast

to eroticized transference, which temporarily makes it difficult to uphold the psychoanalytic situation (see Sect. 2.2.4). Because of the complications that occur in eroticized transference, it would be important to have criteria that would permit predictions to be made while the indications are still being determined in the early phases of treatment and of course to find interpretive means to avoid it. Can we currently specify a group of patients who will fall so in love with their analysts that therapy comes to a stop? Does this group still consist of women who refuse to cooperate in the work of interpretation, and who only desire material satisfaction and are "accessible only to `the logic of soup, with dumplings for arguments'" (Freud 1915a, p. 167)? Too much has changed since the discovery of transference love for us to attribute this quality to the class of "women of elemental passionateness who tolerate no surrogates . . .who refuse to accept the psychical in place of the material" (Freud 1915a, pp.166-167).

First it must be pointed out that this complication has traditionally manifested itself in the analysis of woman who are being treated by a male analyst, for a whole range of psychological, historical, sociological, and nosological reasons. After all, the largest group of women who initially went to psychoanalysts for treatment suffered from hysteria. Since then the sexual revolution has made women's emancipation possible, and this can be seen not least of all in liberal sexual behavior. This late achievement has not changed anything in the fact that sexual attacks and transgressions are much more frequent between men and girls than between women and boys. The same is true for the ratio of father-daughter incest to mother-son incest. The predominant form of sexual behavior between the sexes continues to be heterosexuality in which the males dominate. The expectation of everything that could happen at the analyst's is motivated by the experiences that female patients have previously had with men, whether fathers, brothers, and other relatives or teachers, supervisors, and doctors, to name a few. Seduction and the willingness to be seduced are two phenomena linked by a complicated relationship of attraction and repulsion. The disquieting feeling that is emitted by the phrase "If that were possible back then, now anything is possible . . ." is very strongly dependent on how real the sexual transgressions in tabooed spheres of life were.

Sexual self-determination is one thing. It is quite another that social taboos are being broken increasingly frequently, causing the binding nature of traditional rules of social behavior to disappear. The number of children and juveniles who are abused seems to be increasing, and the number of unreported cases of father-daughter incest is considerable. Transference after abuse, used in a wider sense of the term, is complicated, for traumatized patients put themselves and analysts to demanding tests (see Sect. 8.5.1).

In Sect. 1.7 of Vol.1 we pointed to the fact that the speeds at which changes take place in family traditions and in historical and sociocultural processes are particularly asynchronous. Thus the type of hysterical female patients who not only fall in love with the analyst but who also seek in treatment a substitute for an unsatisfying life and who hold on to the illusion of finding fulfillment from the analyst can still be found in the offices of psychoanalysts today.

With regard to the prediction, i.e., the probability, that an unresolvable eroticized transference will develop or not, what is diagnostically relevant is the kind of complaints that a patient makes about her love life. The danger that irresolvable transference love will develop is minor if the factors making it difficult or impossible for a patient to have satisfactory sexual relationships within existing friendships or in long-term ties are primarily the result of neuroses. The prognosis of illusionary transference love is least favorable if a serious neurotic development has led to the patient's isolation and the patient has reached an age at which her chances of finding a suitable partner are small. Despite all the achievements in women's emancipation, social circumstances have an unfavorable effect on such women, in contrast to the comparable group of men, because, as is well known, neurotic and lonely bachelors have less difficulty making contacts with unmarried women. The different natures of male and female *psychosexuality* play a part in this system, in which for example men looking for partners by means of announcements are less subject to traumatizing experiences than women who are "tested" in a short affair and afterwards found to be not attractive enough.

The reader may ask what these general comments have to do with the spectrum of positive transference. One consequence is that it becomes clear why it is less usual for male patients being treated by female analysts to develop eroticized transference than vise versa under otherwise similar conditions. We do not shy from referring to another general factor, which can be derived from our previous remarks and which according to our experience should be taken very seriously when considering indications. If the combination of biographical, occupational, and social factors described above and that predispose to the development of regressive eroticized transference is present, then a male analyst should critically reconsider his previous experience with eroticized transference before deciding to accept a case. If in doubt, it is in the female patient's interest for the male analyst to recommend that she see a female colleague. In spite of our emphasis on the dyadic character of transference neurosis, of which transference love is a part, the neurosis also contains an independent dynamic rooted in the patient's unconscious schema. If the analyst's age and personal situation coincides with the expectations in the patient's unconscious disposition like the key to a lock, it contributes more to creating emotional confusion. Eroticized transference is the term used to describe such a situation.

But what do confusion and even chaos mean? Are the feelings, affects, and perceptions experienced in transference genuine or not? Even Freud did not dispute their genuineness, although transference implies that it is not the analyst who is really meant, but that the wishes and sexual longing are actually directed to the wrong address. The complete manifestation of a feeling doubtlessly includes reaching the intended goal and, in human interaction, getting the other person to answer and, if possible, to cooperate (Dahl 1978). For this reason the patient is also always referring to the person of the analyst. The latter stays in the background, in order to more easily fulfill his function and also be able to take on the role—whether of mother, father, brother, or sister—enabling the patient to experience the manifestations of unconscious clichés, templates, or schemata. (Freud used these terms to describe a disposition regulating affective and cognitive processes.) The interpretation of resistance to transference helps the patient to weaken his repression; in the process the analyst's catalytic function takes effect and enables a

new enactment to take place according to our enlarged stage model (see Sect. 3.4 in Vol.1). This is the reason it is so essential to proceed from the plausibility of the patient's perceptions instead of from their distortion. We therefore speak of a reenactment with changing roles instead of a new edition. The analyst, insofar as he temporarily has the role of a director, ensures that the patient tests the repertoire of roles available to him—unconsciously, that is—and gains confidence to test the trial actions outside of analysis.

In addition to the above-mentioned group of female patients, there is probably also a considerably smaller group of patients who are only able to complete the transition from rehearsal to real life to a limited extent; this occurs for external and internal reasons and despite the use of the modified technique we have recommended. The less a patient is able to achieve an intense interaction with a partner, the greater the fascination with the empathic and understanding attitude of the analyst, if for no other reason than it is not saddled with the everyday disappointments from actually living together.

A few turns in the following case demonstrate something more general in nature. Much of it culminates in the question of how the analyst can provide confirmation while refusing immediate sexual gratification. In the case of a pathogenic condition caused by repression, the oedipal temptations and frustrations have disappeared to such an extent that the existence of unconscious desires can only be ascertained either from the recurrence of repressed material in symptoms or from the conflicting and unsatisfactory relations to the partner. Finding an access to the patient's world of unconscious desires is a precondition for change, in the process of which the patient increases his capacity for finding new ways to solve problems. For example, the *acknowledgment* of desires that are stimulated and encouraged in the analytic situation by the setting and interpretations is not tied to the *satisfaction* of these desires. Yet it is in the nature of desires and intentional acts to strive toward a goal, and it is common knowledge that reaching the goal is accompanied by a feeling of relief and satisfaction. On the other hand, from the very beginning it is a fact of life that many attempts to attain a goal fail (as in trial and error). If intense,

vital needs are frustrated, defects occur in an individual's self-assurance and sexual role that have multifaceted consequences on his behavior. The technical problems of handling intense emotions continue to be a major test for therapists, who must navigate between the Scylla of subliminal seduction and the Charybdis of rejection.

The patient described below sought security and confirmation in transference love.

A 26-year-old woman, Franziska X, came for treatment because she suffered from intense attacks of anxiety, which occurred especially in situations in which she was supposed to demonstrate her professional ability. She had brilliantly completed her training in a male-dominated profession and could count on having a successful career if she could overcome her anxieties. The latter had developed after she had completed her training, so to speak when things became serious and the rivalry with men no longer had the playful character of her student days. Franziska X had met her husband during her training and they were united by satisfying intellectual and emotional ties. However, she did not get much satisfaction from sexual intercourse in her marriage; it took a lot of concentration and work for her to have an orgasm, which she could have on her own much faster and simpler.

She quickly reacted to the initiation of treatment by falling in love, the first signs of which were already apparent in a dream she recalled in the fourth session. It described, first, a scene between an exhibitionistic girl at a police station and a man who was reacting sexually. The second part of the dream depicted a medical examination in which the patient was observed by someone with X-ray eyes; only a naked skeleton was visible.

The patient's dreams contained repeated permutations of the subject of forbidden love with subsequent punishment or separation. She vacillated greatly between her desire to please me, like a schoolgirl doing her homework, and her disturbing desires, which she also mentioned in her associations.

By the eleventh hour I had already become a "really good friend," who was all her own and who also satisfied the condition that "it" could never become reality. What "it" meant was

clarified by her next association, when she asked me, "Did you see the movie late night about the priest who had an affair with a woman convert?" In the fourteenth session Franziska X told me about a dream.

P: You told me that you were in love and then you kissed me, when I am in love it only goes to kissing, that's the most beautiful part, then the rest comes whether you like it or not. Then you said that we had better stop the analysis. I was satisfied with your decision because I got more this way.

The purpose of this intensive manifestation of eroticism seemed to be to fight her experience that analysis is a phase of "hard times" (17th session). At a weekend seminar she was finally able to get the confirmation, from numerous flirts, that was lacking in the sessions.

P: Yes, what you tell me is really very important to me. I sometimes think that I should try to limit the expectations I place on you or overcome them entirely, because I can never have the hope that you will confirm them. Everything would be so much simpler if I could keep these emotional aspects out of here and have an intelligent conversation with you.

In order to enable the patient to obtain some relief I pointed out to her that the setting (her lying on the couch etc.) and the nature of our talks awakened intense feelings and that it was quite natural that I should acknowledge them. Yet because of the special nature of our relationship and the tasks assigned to me, I could not respond to her desires in the way she wished. I saw an analogy between the patient's insecurity toward me and her (previously disappointed) expectations about being completely accepted by a man, and therefore asked about the source of her insecurity as a woman. In doing so I was guided by the idea that the patient was seeking her mother more than her father in transference love and in her friendships.

This topic moved the patient. For the first time she now talked about her impressions of her mother. In the initial interview she had only stated, "There's nothing to say about her." The patient said she had no image of herself as a woman. She came to speak of childhood memories and described her mother and father as they went to communion at church. As a 4-year-old child she had stayed behind and begun to cry because she did not know what her

parents were doing. She recalled with photographic precision the moment when her parents came back from the altar, kneed, and held their hands in front of their faces: her mother was an attractive young woman wearing a scarf over her long brown hair, like a maid on a farm who is feeding the chickens, uncomplicated and happy.

Then there was a change in the patient's associations. The mother had entered a hospital when the daughter was aged 6; she suffered from eclampsia, which was severe during the birth of another girl. Her mother never recovered. The image of her mother that now appeared in the patient's associations was the one she had when her mother returned home: swollen, ugly, and arms and legs in some fluid to stimulate her muscles. Since then her mother grumbled nonstop in a language that could hardly be understood. In short, she presented the picture of frightening decay, which might suggest more than just oedipal fantasies associated with pregnancy and rivalry.

The patient avoided these impressions and, rapidly changing her mood, turned to another subject and talked about the lovely weather that made it possible for her to come to analysis in a light summer dress.

Being in love became the motor of the treatment. The patient could only bring herself to talk about disturbing and shameful topics when she was in this mood. She felt that she was in a stalemate because her wishes could never become reality.

This greenhouse atmosphere might be described as "transference yes, working alliance no." This constellation pointed to a lack of underlying security, for which the patient had to compensate by showing and offering herself in a seemingly oedipal way.

In one of the following sessions (the 23rd) the patient was concerned with the question of why the analyst did not wear a white coat. "In a white coat you would be much more neutral and anonymous, one doctor among many." During the session this comment turned out to have two sides, one a wish, the other resistance. It became obvious in connection with her short summer dresses that she desired a stronger separation of roles. The analyst had to remain anonymous, and then she could show herself without being embarrassed. The more she

experienced me as a specific individual, the less she could stretch and slide around on the couch. In summer she therefore felt much more like a woman than in winter, when everything is hidden and packed away.

The patient sensed that her erotic attempts to attract me were not succeeding, and she reacted by developing depressive ill will and feeling disappointed.

The development of the transference in the first few weeks and months stabilized itself more and more in one direction. The patient's first attempts to attract my interest were replaced by her anxieties that I would not take a single step toward her. The entire story of her relationship to her father, who had had to take on numerous responsibilities after her mother's paralysis, is too long to be told here. Her father's opinion of her at that time was then, just as it was during analysis, annihilating; "Nobody ever knows where they are with you." This corresponded to the patient's feeling that her father was unpredictable; as a child she had always trembled and been afraid of him.

The development in the first few months made it possible for me to verbalize a growing complaint for the patient. I interpreted that she had tried to win me over and had not reached her aim. Thus frustrated, she simply resigned and became complaining and reproachful.

P: [After a pause] I didn't know who that was supposed to refer to. But, a few minutes ago I thought that the only one that it can really fit is my father. [Silence] Now I recall our church; in it there's a ceiling fresco with a large Lord God, and now I remember our priest and that I was terribly afraid of him.

A: When you think of something else, then the danger quickly appears that I am upset, and then in your experiencing I become similar to your father. You get in a situation in which you have to wait for me to take you back into good favor, as if you were a sinful girl, but this act of mercy will take a long time and really can never be reached.

P: As a 15-year-old I had contact with a young man who had a bad reputation. It was my first love affair, and then he went and got a girl pregnant who was working in the seminary

kitchen. My father scolded me as if I had been the one.

A: In your experience that won't have made much difference.

P: Because of such things our contact never did become very good again. I believe that I am still waiting for the sign of a cross that a father marks on your forehead when you leave home. He didn't do it for me in a way that I can genuinely believe.

In the following sessions the patient continued to be preoccupied with her Catholic past. She had seen a movie in which a woman was also named Franziska and acted the way her father thought she should. She recalled that her father had brought her a church booklet on sexual development at the beginning of her puberty and had pressed it into her hand. Its cover showed just such a young girl: a decent Catholic. It was completely impossible for the patient to imagine that her father had ever been interested in women. She was therefore very astonished when I pointed out that she had had to go into a children's hospital while her mother had been pregnant.

The patient continued to be preoccupied with her particular relationships to older men.

P: Actually I've always dreamed about falling in love with such men, and for a long time I dreamed about sleeping with them. But in reality I wanted a patron who understood me and left me completely alone. Sex isn't a part of it. Funny, since I started analysis these dreams have disappeared.

A: That was also your original idea of analysis, to find in me a patron in whom you can place your unlimited trust and who never gets mad regardless what you might say or do.

P: Yes, that's how it was, but I don't have that feeling any more. I simply think that you can always withdraw, and you're outside the situation; I can't pin you down. You are really more like a computer that organizes ideas and makes suggestions, not a human being, you aren't allowed to be like one. Whenever I think about you I come to a dead-end. On the one hand it starts with my feeling that I find the warmth in your eyes, the intimacy, and

then nothing goes any further and I feel as if I were abruptly awoken, pushed from my dream into reality, as if you were sitting next to my bed in the morning and would wake me up when I dreamed about you at night. And actually I don't want to return to this reality from the dream at all.

I understood her last sentence as an expression of the difficulty of facing reality and discriminating between wishful thinking and a realistic appraisal of my therapeutic role.

2.2.3 Fusion Desires

In a certain context Arthur Y asked me whether I was satisfied with the treatment so far. I said yes but qualified my answer by saying that he, the patient, would probably be even more satisfied if the confirmation would take the form of cash, an allusion to a raise he expected. The patient responded to the analogy by describing the relief he felt after my positive statement. But then he began to feel upset, which he traced back to the fact that I might be critical of him after all. He thought to himself that he might not be contributing enough toward making progress. At the scene of an accident he had recently done everything he could and yet afterwards he had still asked himself if he had really done enough.

In the patient's experience the size of his raise in salary became the symbol of or equivalent to being held in high regard and well liked. He had lost sight of the fact that it would be wonderful to be liked without having to earn it. He referred to this now by surprisingly drawing a parallel to a (homosexual) boarding school teacher he had had in puberty. (He avoided using the disturbing adjective.)

At first the topic of how much affection he could get without taking a very large risk was dealt with by going through the options he had in a forthcoming talk with his boss.

P: Well, I'm willing to do considerably more than is usual but I want to be compensated for it, and the problem is how much I can risk without being turned down. I feel very clearly that I am afraid of two things: that he might reject my wish, and that I might miss a chance if I abstained from asking. That would make me very worried, and something similar is

happening here. On Friday, when I asked the question that I brought up again today, I said that my previous analyst would not have answered it but would have slammed it back at me, just like in table tennis. It wasn't easy for me to ask this question because I was simply afraid of being rejected and of the disgrace and humiliation that go with it.

A: Yet there was one hour when it seemed clear to me that although being rejected is bad, it also reestablishes a distance. The authorities keep their distance.

P: This point seems very important. The distance was supposed to ensure that they don't suddenly act like the [homosexual] teacher at the boarding school. I have to think of the question of who guarantees me that this won't happen if I lose too much of my reserve and I'm no longer myself and you're no longer yourself, but like two pieces of butter in a pan . . . .

A: Yes.

P: . . .that melt in a pan.

A: Hmm.

P: Then they flow into one another.

A: You guarantee it and so do I, for you are yourself and I am myself.

P: Yes, yes, but . . . .

A: Hmm.

P: Now I very clearly feel you've hit me, which tells me, "What do you think you're doing making such a comment?"

A: Yes. Yes, yes, you probably experienced it as a blow, as a rejection, precisely because there is this longing for this flowing together, like with the butter. It's a wonderful image of blending that contains something very profound. Blending, exchange, things in common.

P: And because this cannot be achieved, which is why Dr. A. [one of the analysts who had treated him previously] might have said somewhat sarcastically and with razor sharp logic that what cannot be, may not be. This is a part of it although I wanted to stick to the subject, as I said, it's so typical, the words "razor sharp" . . . .

These expressions were made popular in German by a poem by Christian Morgenstern, "Die Unmögliche Tatsache," that closes with the lines, "And he reaches the conclusion: The experience was only a dream. Because, he concludes with razor-sharp logic, that which cannot be may not be."

A: Razor sharp.

P: Razor sharp, I thought again of a girl I could do something to with a knife. So I have to repeat the word "razor sharp" as often as possible and try to think about something else.

The patient continued in another vein. I thought that I could maintain the connection by referring to something both topics had in common.

A: The point was the mixing, and when the knife enters something an intimate connection is created between the knife and . . . .

P: But a destructive one.

A: Destructive, yes.

P: Outrageous.

A: Yes, an outrageous presumption. No flowing together of butter in the pan.

P: No, no, an outrageous presumption by the one who has the knife, with regard to the other person, who is threatened or injured.

A: Yes, yes, hum, the knife, yes.

P: And the teacher [who had also taken care of the patient when he was ill at the boarding school] had such a knife—not the object, but his behavior.

A: In many regards, in his general behavior and in specific things, with his teeth.

P: And when taking my fever, for example.

A: When taking your fever with his thermometer, which he pushed in, and his penis, which you could somehow feel when he put you on his lap.

P: Well, that I can't . . . . [the patient suppressed the phrase "remember any more."] I've asked myself the same thing. But I don't think so. At least I can't remember.

A: It's possible that this has been lost and that he . . .

P: he understood . . .

A: how to hide the fact that his penis was presumably stiff.

P: Yes, we can assume that. Well, I mean I can't remember. Thank God that it didn't get that far, but I still felt threatened and very much in danger. Yes, similar to here. On the one hand, the feeling of being helplessly exposed. I was sick after all and didn't have a chance to say that I would like to have someone else take care of me. No trust. Well, here it isn't always that way, only if I try very hard to think about it. Then somewhere I feel a reservation about going so far because I wouldn't be able to defend myself. Of course, my personality and yours are guarantees, but simply by your saying it I make it into a rejection.

A: Yes, because the flowing together expresses a longing, namely to get enrichment by taking as much of my fat as possible, thus if at all possible not only a raise but a million's worth of affection, as an expression of strength and potency.

P: Yes, all of what you just said gives security. But I have to think of the following: Okay, what should I do with this longing for affection if it's impossible for them to merge to the same

degree as two pieces of butter? So, get rid of it.

In a later session the patient described the mixing by referring to two bars of chocolate, thus revealing the anal origin of the reference and its different unconscious aspects.

A: Why get rid of it? Who says that it can't become reality and you can't retain something from here?

P: Yes, yes, either everything or nothing.

A: And you cut a piece of fat off my ribs with the knife.

P: [Laughing] Because I always have the tendency, everything or nothing.

A: Well, you've also discovered that you can be very curious in order to get more, everything if possible.

P: What kind of concrete example are you thinking of?

A: Hmm.

P: Because I wanted to know where you are vacationing . . . .

A: Yes, that is the example I was just thinking of, because that was also a matter of burning curiosity. And then you would like to have a steadfast man you can't disparage, who asserts his independence, because otherwise he would be a weakling.

It is always especially impressive and convincing when the patient's and analyst's thoughts coincide. Then, after a pause, the patient spoke about his boss.

P: You used the words "longing for affection." There was another word. "Longing for agreement."

A: Things in common.

P: Yes, yes.

A: Hm.

P: That is something that has worried me my entire life, when I had my first experiences with girls. It was with my wife that it happened for the first time, that I didn't lose all interest the moment my affection was reciprocated. If they became weak, then they lost almost all value.

A: Yes, yes, weak.

P: Or vice versa, if I showed a feeling of affection to someone, whoever it was, and if it weren't reciprocated immediately, I became aggressive. I not only withdrew my exposed feelers but became more withdrawn. It was an incredible humiliation for me. Just like the fact that the two of us can't simply and completely blend together, like the butter.

A: You mentioned that you used to be more aggressive. At some point there must have been a reversal, to being self-deprecating and self-critical about not being able to finish anything, when you started making yourself the object of accusations.

P: I can now see these two pieces of butter. In religion and in communion you find just the same thing.

A: In communion.

P: In communion, in union, in eating the body, I'm not the only one to have this wish; there are millions. It's simply a part of me because I'm human.

A: Yes.

P: And not because I once knew this teacher.

A: Yes.

P: So it's nothing that I have to continuously struggle against or disparage, nothing that robs me of my value as an individual, it's rather something that belongs to me because I'm just like the rest.

A: Yes.

P: And now you'll say right away that you are also an individual, have feelings just like I do, and it must be possible to make the thing with the butter come true.

A: Yes.

P: On the other hand, ha ha, but just a second, otherwise this will go too far. Of course, you are right. This is so contradictory, just as my mood can sometimes swing within seconds, like a scale trying to get into balance. But my mood doesn't stay in balance. And now I think that if I really manage to go to my boss and talk about money, then maybe he will also think, "Maybe he could do something for nothing once." He will somehow feel disappointed if I demand something from him for what I do, since he's only human. I would have to manage to sacrifice a part of this all-or-nothing standpoint that a hundred minus one is simply equal to zero, but rather that one hundred minus one is still ninety-nine and one hundred minus fifty is still half. Can you understand me? This is so hard for me.

A: Well, yes, a hundred percent is in fact nicer, hm.

P: Yes, but one hundred minus one is still . . .

A: Ninety-nine.

P: And for me ninety-nine turns into one. I'm much more interested in this one part of a hundred than in the other ninety-nine.

A: And everything is invested in this one part, and then you yourself are nothing.

P: Yes, if I can't have everything, then I don't want anything at all. But emotionally I'm still

waiting for the bang that happens when I learn something like I have today. Dr. B. used to say, "Then your anxieties will explode like a balloon. Boom, boom. And they're gone." I'm still not finished with it, but it would be lovely if it were possible.

A: I have the feeling that you are happy about the discoveries you've made today, but that you don't really dare to express your pleasure and thus to belittle your discoveries right away. Perhaps you're also disappointed that I'm not dancing with joy at the profound connections you've discovered.

I later thought about the missing explosion prophesized by his earlier analyst. That such an exaggeration, which made the analyst into a magician performing wonders, unconsciously had to lead to the patient's anal disparagement, which in turn prevented both the explosion and a stepwise improvement from occurring, was shown by the history of this patient's illness.

2.2.4 Eroticized Transference

Gertrud X, a 33-year-old woman, was referred to me by her family physician because of frequent depressive episodes, which had already led her to make several attempts to commit suicide. The patient complained also about frequent headaches. In numerous talks her physician had attempted to give her support, but in the meantime her relationship to him had become so tense that he did not feel he was in a position to look after her any longer.

The conflict situation was as follows. The patient was an only child, and she had lost her father in the war when she was 3 years old. Her parents' marriage must have been marked by tension, and her mother had not established any close ties to anyone since then. At first she established contact with her brother's family. The patient also greatly admired her mother's brother, who died in the war when the patient was 5 years old. Her mother's father also played an important role; he was an dominating authoritarian who, just like the rest of the family, was staunchly devout. She portrayed her mother as someone who was rather infantile and dependent on the opinions of others and who attempted to tie the patient to her.

A positive development had taken place about 6 years before the beginning of therapy

after the patient had established a friendship with a younger (female) colleague, which made it possible for Gertrud X to put some distance between herself and her mother. Now this colleague was planning to get married and move to another location. The patient felt herself exposed to increasing attempts by her mother to cling to her, and reacted by provoking aggressive clashes. The patient had never entered into closer heterosexual friendships. Her relationships to men were characterized by her effort to find confirmation, yet her frequent provocations put their goodwill to a serious test.

In the initial interview the patient appealed especially to my willingness to help, and in particular knew how to describe in a convincing way a long chain of experiences in which she had lost someone. I offered her therapy, whose goals were to reduce conflict, both in her separation from her mother and in her attitude toward men.

Although Gertud X accepted my offer, to my surprise she expressed doubt from the very beginning about the success of analysis. She expressed skepticism especially regarding my age. She said that she was only able to establish a trusting relationship to older men; I was about the same age as the patient. In view of her aloof reservation I paid especially careful attention in our interaction for signs of a flickering of friendship, a desire for confirmation, or erotic interest. The patient rejected interpretations in this vein in a standard way, constantly emphasizing that there was no point in me concerning myself with her in this manner. My interpretations only caused the patient to become more cautious. My attempt to break the ice by interpreting deeper unconscious wishes only had the effect of offending the patient, who reacted by becoming depressed, thinking of suicide, and retreating. These alarm signals led me to be very cautious.

Yet despite all the patient's recalcitrant reservation it became impossible to overlook the fact that her interest in me was growing. She was overpunctual in coming to her sessions, concerned herself increasingly with their contents (even though primarily in a critical way), and started using a perfume that made her "present" in my rooms for hours after her appointment.

These changes were indicative of a new topic in our interaction. With the increasing

length of therapy the patient's mother became increasingly jealous, in particular because, according to the patient's reports, I frequently functioned as the star witness in their disputes. Her mother called me twice, attempting to gain my support by complaining about her daughter; I rejected this attempt from the very beginning. On the contrary, the patient's independence became a preferred topic. The patient explained in great detail about her mother's countless attempts to interfere and about her infantile nature and jealousy, and came to me for support in her struggle for more independence. In this phase of therapy our interaction was largely free of outright tension.

The first summer break, which lasted several weeks, was a turning point. There was little indication of this change in the period immediately preceding it; the patient's conflicts with her mother had instead been the prime topic. It was not until the last hour before the vacation break that the patient appeared alarmingly depressive and skeptical. Without wanting to, I adopted the role defending the therapy while the patient continued, without interruption, to deny the value of every positive sign. On the evening of the same day the patient phoned me and spoke openly about her intention to commit suicide. She got me involved in a long telephone conversation, in which we went through the contents of the last session once again.

During my vacation Gertrud X turned to her family doctor again and sought support. An intense dispute developed very quickly, whereupon she took an overdose of sleeping pills and had to be admitted. I detected a trace of triumph in her description of these events. Our interaction after the summer break had resembled that at the beginning: the patient had been skeptical and pessimistic with regard to the success of the therapy. Proceeding from her experience in the summer break, she emphasized over and over that there was no point to her having any hope. Sooner or later she would again be alone and without any human support. Envisaging her next attempt to commit suicide, I tried to show the patient my sympathy and explain to her that it would extend to her beyond the end of therapy. Although I recognized the aspect of extortion in her statements, I did not make it a topic because of my fear of further complications.

My own private situation aggravated these conflicts in this phase of therapy. The patient

did not have any difficulty finding out that I was in the process of getting a divorce and that my family had moved to another location. This fact was only very briefly mentioned in the therapy, but I noticed that the patient tried to find out more about my private life by following me in her car. I transformed this fact into the interpretation that the patient had become curious and fantasized about sharing the future with me. As a result of this interpretation, she again attempted to commit suicide by taking sleeping pills; hospital treatment was not necessary, but this event increased my vulnerability to being blackmailed. The patient began to call more frequently after the sessions. Although I regularly referred to the necessity of discussing these things in the next session, I no longer dared to force them to a conclusion and thus over and over again let myself get involved in long disputes on the telephone. This constellation remained stable for a very long period of time. In the sessions the patient was silent and rejecting and emphasized the hopelessness of the entire situation. I attempted both to encourage her and to confront her latent rejection; in general she reacted by becoming offended and frequently called me after the sessions "in order to get over the weekend." Although I noted that the patient's social conflicts with the outside world settled a little and that she had fewer conflicts with her supervisor in particular, this had little significance for the therapeutic process. In view of this stalemate I did not dare steer toward ending therapy because there was a very large danger that each announcement of an end would be answered with an attempted suicide.

The culmination and end of this tormentous clash was a call in which the patient said that she had just taken a dose of sleeping pills that was probably lethal. She called me from a telephone booth not far from my office. Rapid action was indicated in this emergency situation. I immediately picked her up with my car and took her to the hospital. This joint trip in my car and handing her over to the emergency care doctor on duty etc. naturally provided her with a large amount of transference satisfaction. For a brief moment it was as if the patient and I were a pair, even if an estranged one. Yet our relationship reached a point here where I had to tell her after her release from the hospital that she could force me into an active act of providing medical help, but that she had thus also lost me as analyst because I could no longer help her in that capacity. Subsequently she tried to make me alter my decision by threatening to commit

suicide. Yet my steadfastness at the end of treatment made it possible to find a halfway conciliatory conclusion.

Commentary. The treatment described here resulted from a series of mistakes that are typical for beginners. Yet a beginner's mistakes often reflect an understanding of treatment characteristic of the school of analysis he adheres to. In retrospect it is possible to identify the following undesirable developments:

1. Attempts to master the ongoing crisis situations solely by working with transference and resistance is insufficient if it is not linked to an improvement in the patient's real life situation. The patient had to be reconciled to the possibility, in fact the probability, that she would never marry; the fact that the analyst wakened unrealistic hopes therefore had to have antitherapeutic consequences. Unreflected rescue fantasies on the part of the therapist had an unfavorable influence in this case.

2. Since the patient had no partner, focusing on unconscious transference wishes had to have an antitherapeutic effect because, once again, the forced reference to transference wishes aroused unrealistic hopes. In the initial phase the therapist fell into the role of seducer, and this role had harmful effects on the rest of the analysis.

3. A topic that went untreated, especially in the first third, was that the patient employed the therapy as a weapon against her mother and that the therapist was led into taking sides. As a consequence, the patient's aggressive impulses, whose development was inevitable after her hopes had been disappointed, were directed onto someone outside therapy, which paved the way for the later, unfavorable collusion.

4. Following her serious threats of committing suicide, the analyst gave the patient more sympathy than can be maintained in an analytic setting. This obstructed the interpretation of her aggressive impulses, especially her using the threat to commit suicide to coerce the analyst. The patient's preexisting tendency to treat the analyst as a real partner was strengthened precisely in this phase of therapy, without patient and analyst jointly reflecting on the role transference played in maintaining her self-esteem. The therapist's family situation, which the patient was somehow aware of, increased her illusory hopes. If an unmarried patient

who cannot cope with being alone happens to have a therapist who is the right age, alone, and possibly even unhappy, then the social reality of this constellation is so strong that it is probably extremely unusual for them to be able to focus on the neurotic components of a patient's hopes. Expectations and disappointments that have antitherapeutic consequences are almost inevitably the result.

5. It was almost inevitable that the therapist, under the burden of the disappointments and complications that he at least in part caused, would not be able to resist the pressure of his own feelings of guilt and let himself get tied up in telephone conversations justifying his procedure. In trying to justify himself it was almost a matter of course that the therapist's arguments were dictated by his own interests and not by the patient's needs, which in turn promoted the patient's secret hopes of overcoming the limitations of the therapeutic setting. Indicative of this was the fact that the therapeutic frame only regained its importance the moment the therapist admitted his failure and announced that it meant the termination of therapy.

2.2.5 Negative Transference

Negative transference is a special form of resistance that can destroy the analyst's ability to function. Has therapy reached a standstill? Is the patient one of those people who somewhere in their mind desire change—otherwise they would not come—but who at the same time deny that the analyst has any therapeutic influence? How do the patient and the analyst each cope with a chronic impasse?

The analyst can maintain his interest by attempting to recognize the reasons for the negative attitude that eludes his influence. This can be linked with the analyst's hope of interrupting the repetition and at least transforming the rigid front into a mobile war and outright hostilities. It is not difficult to recognize in this martial metaphor that the analyst suffers from such a paralyzing balance of power. One means of making it easier to bear this powerlessness is to detect the secret satisfactions that the patient derives from being able to maintain and regulate the balance of power. This is linked with the hope that knowledge of the destructive consequences of this pleasurable ability to exercise control can also lead the patient

to finding new paths to gain pleasure. Abandoning the usual track and seeking free space is tied to a renunciation of security that no one gladly accepts as long as no new and promising sources of pleasure are apparent and, what is even more important, as long as these new sources do not flow precisely in those moments when people thirst for them.

In the last session I had plainly pointed out to Clara X, a patient with anorexia nervosa, that there was a deep and wide gap separating what she said here and how she acted outside—and in general between her thinking and her actions—and that she separated both spheres of her life from one another. I attempted to impress on her that although she suffered from this dichotomy, she also maintained the power embodied in it and that I could not do anything about it. The sense of what I said was, "You are powerful and I am helpless, and I can feel that your power is a strong force." Outwardly she seemed peaceful, she was a peaceful dictator, and she was not even aware of her awesome strength that made me helpless.

In her first utterance in the following session the patient referred to the blow I had given her when she, referring to the fly swat that was lying around, asked, "Do you kill flies in the winter?" And immediately added, "Do you use it to hit patients?" To my interpretation, "You are thinking about the last session," she immediately responded in a reflective manner, "Yes, it hurt me very much."

P: I understood your *criticism* to mean that although I regret not being able to do anything, I do it willfully, that I insist on my habits in order to keep you from interfering, in order to maintain my independence.

A: But not maliciously. It's difficult not to immediately take my thoughts to be criticism. Otherwise you could view your habits self-critically and perhaps see and sense that there might be other and larger opportunites for satisfaction. But by closing your eyes and retaining something that has become very established, you have very little space left to change something and go your way.

P: My perseverance can be much worse. You should inquire about the question of my weight.

The patient then spoke about the only item that might motivate her to sacrifice her perseverance, namely her desire to have another child, but this desire was immediately blocked by the thought that she would then be the prisoner of motherhood again. I picked up this line of thought:

A: Not to persevere would lead to an ambiguous goal, to becoming a mother again, which you experience to be a prison.

P: But then I would have to deny several characteristics even more fiercely. Then I would have to be feminine and patient, wait at home for my husband, be in a good mood and try to please him, try to be as nice as possible and speak with a gentle, soft voice. But beware! This doesn't include having pleasure from physical movement, and social contacts have to be largely abandoned, and I would have to forget any ambitions to have a career. One ambiguous situation takes the place of the other. My deepest longing is [pause] to be accepted all around and to be able to accept myself.

A: In other words, to overcome these contradictions.

P: To overcome them by having a second child is an illusion, I would get just as much negative feedback about not being a good mother and doing everything wrong.

A: I believe that you have a deep longing to overcome these contradictions, but that this feeling is unsettling. You refer to these examples in order to wipe away the shame from your demand for instantaneous nursing. You do everything to avoid this shame, which also prevents you from having more happy moments.

After this interpretation the patient replied that she simply could not see how anything could be changed by talking.

Consideration. I had the feeling I was acting as if I wanted to make something especially appealing for her, as if an angel strengthened my powers of persuasion. I surely had this fantasy because the patient some time ago had copied a painting by the pre-Raphaelite Rosetti, "The

Annunciation," and brought it along with the comment that the fragile Maria in the painting, showing signs of cachexia, was probably an "anorexia."I alluded to this in my next interpretation.

A: I am just like the angel proclaiming the Annunciation, and you are the anorexia Maria who is an unbeliever. An angel helps me be persuasive, but I turn into a devil who deceives, and you are intelligent enough to know, and you do know, that such persuasion lies because the salvation that it promises doesn't last.

Then the patient—as if in prayer and after a longer period of silence—made the following statement:

P: Hum, who took You, oh Virgin, to heaven, praised be the Virgin Mary, blessed art thou, naturally I don't believe, after all I have a heretic as father who is sitting on a cloud in heaven, but not because St. Peter let him in, but because hell was overfilled. You also said, however, that he was too much a heretic and what he said was much too unbelievable.

A: You could give me a chance to let my words resound in your ears as if they were sent by an angel, and above all you could give yourself a chance.

P: But Dear Lord, do I need a second child to get rid of this feeling of being torn apart?

A: No, I don't believe that you need another child to do it. In your own mind you already doubt whether it is worthwhile to have a second child. And then you've got the ambivalence again. The second child is a prison for you. Do you want to get started on your way to prison? Nobody wants to do that. The point is thus to give the persuasion and your own hearing more of a chance when you make a decision that could land you in prison. The point is pleasure, pleasure for its own sake, but you will always be more likely to find it where you find it now, for example, when you eat something at night.

P: [After a pause lasting about 4 minutes] The thought of gaining weight and eating doesn't have anything to do with pleasure or with the feeling of being able to accept myself or of

having accepted myself or of being accepted. I can only do it because of the insight that it might be necessary for another child, but not otherwise. When I'm well armed, then I enjoy my inner contradiction as undivided pleasure.

A: That is the goal, the undivided, the unambiguous pleasure, not a divided pleasure.

P: I'm sorry, that is something that does happen, but just for seconds and hardly when the object is bread or food or the classical ways of having a good time. Now I can see a funny image. If the Anorexic lets herself get involved and starts to extend her finger, this unusual hermaphroditic figure there, Gabriel or whoever it is supposed to be on the picture, is left hanging, whether the angel is masculine or feminine? In one hand it has a bough of lilies, in the other the fly swat, and if it extends its finger out too far, then the finger gets swatted one. Think of the fact that being a mother is a large responsibility.

A: Just don't stretch out your finger too far and hold the lilies under the angel's nose to smell, and then there is the ugly word "anorexic," not very nice, *Hexe* [witch], *anorexe* . What you give yourself, so to speak, in anticipation of the fly swat, of being hit by the fly swat. You used the ugly word.

P: I always do that. I use all the words to describe myself that others have ever used to describe me and that have been offensive. It makes my condition bearable, the age-old technique of anticipating the attack by inflicting it on yourself. A very helpful invention.

The reader should not overlook the fact that Clara X just provided an accurate definition of "identification with the aggressor." Therapeutically it was a disadvantage for this process to repeat itself after my aggressive interpretations and thus to become stronger.

The last part of the hour was concerned with immediate statements.

A: You asked me to be direct and blunt in telling you what is important and not just to say everything indirectly. I believe this is something you're demanding of me and of you yourself too. You want to hear loud and clear what is frank and unambiguous and

undivided. You want out of the ambivalence. That is the problem over and over and is especially true today. I almost would like to thank you for giving me the opportunity.

After a long period of silence in the next session the patient said in retrospect, "Yes, after the last session I really had a feeling of unity and satisfaction. If I say anything, it could get broken again."

A: Yes, the topic was permission. And I had the same feeling you do, I even thanked you for it.

P: Although I don't know what you want to thank me for.

A: Yes, it's an expression of my happiness. I had the feeling, yes, . . .[falteringly] that the wide gap separating us, it seemed to me, got smaller.

P: Yes, do you think there's a wide gap?

A: Yes, I see a wide gap between action and behavior, action, behavior and speaking, and talking and thinking.

P: Don't you also have the feeling that when you start talking it starts getting controversial right away again?

A: Yes, that might be, but there are also points of agreement. There were also some in the last session. Thinking, acting, and speaking are not the same, but these spheres don't have to be as far apart as they are at times in your case. There are optimistic signs that more things are converging.

P: [After a two minute pause] Oh well, that's why I don't dare say what's on my mind. I think it might disappoint you again. And now you can say, "But I'm used to it."

A: No, I wouldn't say that—although it's true—I would rather say that it is a hard path, one filled with disappointments. You know that's how it is.

P: What I was thinking about is why I have new disappointments, more than is normal.

A: Perhaps it's related to the fact that things get too hot when they get closer, and that you become unsettled and retreat when you get closer to somebody.

Clara X again turned to the subject of her role as housewife and mother and to the question of a second pregnancy and whether she should, in this regard, force herself to gain weight. She told the story of an infertile woman, and considered herself a failure if she didn't "make" a second child. In the process it became clear that her body feeling had changed in the last few months, probably as a result of the therapy. I agreed with her that I also supported the goal of reaching a changed body feeling and, as a consequence, of her reaching a normal weight. The patient's anorexia had begun soon after her menarche, so that she had become amenorrheic very early. She had conceived her healthy son following a hormone treatment. The patient knew, after I had explained it to her, that her cycle could not set in before she had at least approximately reached a certain weight. The hormonal regulation of the menstrual cycle is so closely correlated to the amount of body fat that the absence or reoccurrence of menstruation can be predicted from a woman's weight. Psychogenic factors play only a minor role in the disappearance and reappearance of the period.

Clara X refused to fulfill the necessary preconditions for having a period, i.e., to return to a normal weight. She said that this held no promise for the future, it didn't motivate her.

A: Why is this way of reaching a new body feeling only sensible if you have another child? In my opinion you would reach normal weight if you had a different feeling toward life, one that you could develop with more pleasure, and maybe here and there with more disappointment. I see other things in addition to a child. I am an advocate of normal weight, but you put me in the wrong category. I'm convinced that you would feel better. If you think you would disappoint me, it's because you've come close to some very hot feelings, to the hot oven itself.

Commentary. The struggle over the symptoms and goal of changing her weight took up too much space. The negative transference was not traced back to the disappointment of the patient's oedipal wish for a child in transference. One allusion in this direction was not

developed. The analyst's remark about approaching the hot oven was an allusion to the patient's sexual feelings; she had frequently used this phrase to refer to her sensations and her genitals. Of course, there was another, deeper aspect, so that the analyst's failure might also have been the result of insecurity. The patient's longing for her mother and to become a mother again might have been behind the topic of having a second child and the talk about her body feeling. The patient incorporated this longing in a simile about a good fairy, in whose lap she could bury her head. The patient used the negative transference and negativism to protect herself from the disturbing fusing and, ultimately, also from separation as well as from simple disappointments and rejections.

After reading this report, Clara X supplemented it with the following dialogue with a fictive reader:

Reader: I was very interested to read what your analyst wrote and thought it was fairly reasonable. What do you have to say about it from your point of view?

Clara X: When I glanced through the text for the first time, very quickly and feverishly, I asked myself whom he was talking about. Am I supposed to be Mrs. X? Did he ever tell me that? I found some expressions and details that could only stem from my own analysis, but I had simply forgotten many things.

Reader: Well, forgotten?

Clara X: The passage from my analysis that it refers to was a long time ago. Besides, I think this Mrs. X is most unpleasant, even repulsive. I can see her in front of me on the couch—I am sitting behind her—like a fat black dung beetle incessantly paddling in the air with her legs and rasping, "I can't get any where, oh, I can't, I can't!"

Reader: A dung beetle on its back is really helpless.

Clara X: Yes, but I'm afraid that if beetle Mrs. X is offered a straw to climb in order to turn over,

she would only growl, "I don't like straw! Either I get an orchid or I stay where I am!"

Reader: By using this image—it comes from Kafka, doesn't it—you repeat what your analyst referred to as "negativism beyond my influence." You have even taken his seat. Is what he said about you really correct?

Clara X: I have the feeling it is. It's probably much too true, and it makes me feel ashamed. According to my idea of what I would like to be like, I move forward on my own two legs. Just why was I that stubborn in analysis?

Reader: You don't want any help, not even a straw.

Clara X: That's nothing new to me! I want to justify myself; I want to pluck apart what disturbed me, why I acted this way and accepted so little of the help that was offered to me. But it doesn't lead to anything but a repetition of the moaning that I've already gone through in therapy.

Reader: Tell me anyway what you have to moan about.

Clara X: I've always felt deeply disappointed. I longed for something closer, more direct, for aggressive physical contact, as it were. I'm much too experienced in throwing words around. Despite my own longing, I can use language to perfection to keep my partner at a distance. I was raised with words. My parents talked more than touched. My mother said herself that she wasn't able to really enjoy her children until she was able to talk to them: "I can't and couldn't do very much with little children who crawl on the floor, babble, slobber, smear their food, whom you let ride on your knees, and with whom you cuddle and be silly." The climate in our home was not cold, but cool, like the days in early spring. You could smell the promise of sunshine and violets in the air, but you still shivered and needed a sweater . . . .

Reader: And this promise naturally wakens an immense longing.

Clara X: Precisely. The merry month should come finally. And instead, the next cloud, the next

hail storm. Parents demand that a child be reasonable, control himself, be understanding. They appeal to his pride that he is already big . . . .I recreated this state in therapy. And suffered from it. Incidentally, I've acted the same way toward my son. He was able to talk very early. When he would come into the kitchen when he was nearly two, to be close to me, I had the urge to interrupt my work and pick him up. And what did I do instead? I *told* him that he could play with the pots.

Reader: Can't you also overcome this distance by speaking?

Clara X: Fortunately I know I can. Sometimes. I distinguish between language and talk. For example, you can say "the language of anger" or "the language of love," but not "the talk of love." At the most we talk *about* love. But it's worthless straw, while language . . . .

Reader: is the grain that bread is made of.

Clara X: You understand me. When two people speak with one another, something really happens. During therapy I lost much valuable time talking *about* facts, going in circles, about some symptoms. I'm afraid I sometimes led the analyst around by the nose, unconsciously, and he trotted around behind me, going in the same circles.

Reader: Do you think so? At least he must have had a lot of patience.

Clara X: Yes. And I could hardly imagine when the talks were so unproductive that he might also be paralyzed. I admit that I was happy that I was able to affect him, hurt him. But a child only perceives its own—presumed—helplessness. He once even called me a tyrant, while trying to clarify a resistance. *That* hurt, and I'll never forget it. I was outraged, and while going home I recited to myself the opening lines of Schiller's *Die Bürgschaft* , "To Dionysus, the tyrant, crept the demon, carrying a dagger . . . ."

Reader: Something like that can get things moving again, can't it?

Clara X: Moving—yes! I was hoping just that would happen when I tried to arrange situations in which he and I would do something together. I'm disappointed that I didn't learn to be

more spontaneous. For example, I suggested that we spend one session walking.

Reader: What came of the walk?

Clara X: We didn't get beyond discussing it. He didn't think the suggestion was entirely absurd, unacceptable, or childish. He left it open—then I gave up the idea myself. My motivation was gone. The motivation and the pleasure. I'm disappointed that I didn't learn to be more spontaneous.

Reader: But despite everything, you liked going to therapy?

Clara X: Yes. After all, I felt I was being given more attention and understanding than by the people allegedly close to me, the ones I had ties to in everyday life. My resistance was more; it was a sign of my constant devotion, if not to say a declaration of love to my analyst. Unconsciously I was saying, "Look, I'm retaining a couple of defects so that I need you. Because I know that it's good for you, like for everyone, to be wanted. I bring my sorrows, my inner images (and sometimes even real pictures), and my money to you regularly and punctually. I do my part that you have a task to do and can earn a livelihood. And at the same time I watch out that I don't claim too much of you, don't take too much of your time and strength, because I only make limited use of your advice on the outside."

Reader: Hum. Sounds a little megalomaniac, but seems convincing to me.

Clara X: That's why I find the expression "negative transference" insufficient. My attitude was fed in part by feelings that I felt to be positive. When my mother used to say, "I don't have to worry about my daughter; she just runs along, she is stable, thank God," then my little ears took it to be strong praise. I thought that my analyst would also have to positively acknowledge my inclination to only accept a very limited degree of help.

Reader: I just had a thought. If somebody prejudiced against psychoanalytic treatment is listening to us and collecting counterarguments, then this is a real treat. The therapeutic

relationship that maintains itself. The client conserves her symptoms because the couch is so nice and familiar to her!

Clara X: Sure. I know such people. Let them listen until their ears ring. They only hear what they want to. But I know that I have changed. There's been a radical change in the circumstances of my life, as a result of my own action. With the emotional support I had in therapy, I was able to untie the knot, something that seemed impossible years ago and that I tried to escape from by dissolving into nothingness. It's possible that that untying this knot was the only task I saw throughout all the years of analysis. The other kinds of problems were also important, but ultimately maybe secondary.

Reader: That sounds positive. But may I nevertheless make a critical comment?

Clara X: I know that you're just as crazy as I am.

Reader: Huh?

Clara X: Somebody who tacks a "but" onto every positive statement! Shoot!

Reader: Among the other, allegedly secondary kinds of problems are your eating habits, weight, looks, health, body feeling, ability to tolerate the closeness of others, no, to perceive this closeness as satisfactory and not to always run away . . . .Aren't you cheating yourself tremendously when you refer to everything as secondary?

Clara X: Heavens. I don't consider myself cured. But I don't blame it on my therapy, and it doesn't make me feel inferior. I know that I'm in danger, and I like to balance my way along the edge. But maybe I will be able to handle it better in the future. In the meantime I'm having enough fun in life not to "beat it" voluntarily.

Consideration. It was impossible, retrospectively, to overcome the deficiency that Clara X complained about, and the question whether the therapy would have been more successful if . . . must therefore remain unanswered. This "if" can be tied to many conditional clauses. Should I have stood up immediately and gone for a walk with the patient? And what would have to have

happened during the walk to create the new beginning in the sense of the spontaneity that Clara X was longing for? Once, without any previous announcement, Clara X invited me to breakfast, which she had brought along and spread out on the table in my office. I was naturally surprised but not irritated, and behaved, at least according to my perception, completely naturally. I had already had breakfast, and so I drank a cup of coffee. Clara X had fruit and a whole grain cereal. What she had expected of this arrangement stayed unclear, and in retrospect it was not a success.

Commentary. Since subsequent reflection about which real or symbolic wish fulfillment would have facilitated a new beginning for Clara X is idle speculation, we will mention a few of the general points that guided the analytic strategies. It is advisable to take complaints and accusations seriously in a comprehensive sense. This widens the scope of psychoanalysis without leading to transgressions that are ethically dubious and technically fatal. In the standard technique the limits were surely drawn too tightly, a fact which was partly a side-effect of Ferenczi's alarming experiments. Aside from flexibility, however, the analyst must be aware that a patient's complaints and accusations about deprivations and deficits in his relationship to the analyst fulfill a function that originates in neurotic dissatisfaction. If the analyst assumes that defects and deficits definitely result from what happens to someone in childhood and in the course of their life, then there is little chance for change. Strictly speaking, these events cannot be put right in retrospect. The professional means of psychotherapists, whatever their provenance, would in any case be subject to narrow limits. Anna Freud (1976, p. 263) took this position, that namely an individual can only change what it itself has done, but not what was done to it. This argument pays too little consideration to the fact that the incapacity to act constitutes neurotic suffering. A patient's accusations about not being offered enough in therapy are assertions that also serve to protect himself against not having to take the risk of fulfilling the potential for his own thoughts and actions. The analyst was obviously not successful in sufficiently freeing Clara X from her self-induced limitations to enable her to reduce her complaints about deficits in present and previous interpersonal relationships. Although individuals with anorexia nervosa deny that they suffer from self-induced hunger, the condition continues to maintain and reinforce

a deficit state. Kafka's *Hunger Artist* complained that a fundamental deficit in maternal love was the cause of his fatal illness. After the artist died of starvation, Kafka has a panther take his place in the cage. The short story concludes with the panther being shown to the audience in place of the artist. It is not an easy task to reconcile a patient with the pantherlike components of his own self.

2.3 Significance of the Life History

2.3.1 Rediscovery of the Father

Twenty years ago Friedrich Y suffered numerous periods of serious depression; the symptoms were so serious at that time that psychotherapy was not even considered. After an initial outpatient therapy with an antidepressive, lithium was administered as prophylactic medication, which has continued until the present day. Although psychotic mood swings had not become manifest in the meantime, Friedrich Y reported that he fell from states of high spirits into black holes.

He had postponed his desire to seek psychoanalytic treatment for a long time, and could now for the first time take the liberty of having one and was also willing to wait a long time for it. He sought therapeutic help because he had felt "walled in" for years. He described his condition with the image that he lived under a layer of concrete that he has to break through every morning after waking up; he reasoned that this condition stemmed from the years of treatment with the lithium medication. The indications for psychoanalysis were the depressive disturbances of the patient's ability to work and of his interpersonal relationships, which were very comprehensible psychodynamically and were probably due to neurotic conflicts.

After one and one-half years of analysis the patient had made great progress, particularly in his capacity to assert himself at work. As a consequence of these changes, which made a great impression on him, he wanted to make the attempt to get along without taking the prophylactic medication of lithium. The question of the medication's somatic and psychological side effects had to be taken into consideration in making this decision. Schou (1986) reported

that patients occasionally describe a modification of their personality as a result of lithium treatment. After considering the entire course of Friedrich Y's illness, his psychiatrist and I made the decision that the lithium medication could be gradually reduced and eventually discontinued.

The following sequence describes a phase from this period of time in which my worries and anxieties in view of the responsibility I had nolens volens accepted can also be seen.

Friedrich Y demonstrated again today very clearly that he had made great progress. Yet I was preoccupied by how little he knew about his father, a fact we had already spoken about several times. His memories of his father, who had died when the patient was 13 years old, hardly went further back than to the age of 7 or 8. This period of his childhood development appeared blurred. Although he knew a lot about the time he had spent with his mother, with regard to his father he could only remember a few Sunday walks and that his father had worked in his workshop "as if he were crazy." The shop was in their house, and his father, a Swabian craftsman, retreated there to avoid his wife, whose ideals of order and obedience ruled upstairs.

As a boy the patient had usually not been allowed into the shop and had been very distant to his father. He got all the more under the thumb of his pious mother, under whose upbringing two older sisters were already becoming depressive. The same thing happened to him; he experienced states of severe depression when he left home to begin studying at the university.

With this previous history in mind, I attempted to make him aware of the distance between us by telling him that he described exciting developments taking place outside and I could watch with great pleasure how he was unfolding, but that I noticed, alluding to transference, that he hardly perceived my workshop. He would barge into the room, lie down on the couch, take his glasses off, and not see anything else of the momentary situation.

He confirmed this, laughing. Just today he had noticed this as he took his glasses off. Moreover, there had been a time when he had trained himself to look out of focus, in order to be able to concentrate fully on his inner images and thoughts. When I emphasized his

pretending to be blind, he interrupted me.

P: This is like being in front of a pane of frosted glass, glass like that in the door to father's workshop.

A: Yes, that's a remarkable parallel. But it is also surprising that we still know so little about you and your father after more than two years, as if his death had completely obliterated him, and that we know little about what you perceive here.

P: [A short period of silence] That's true. I'm very happy about the good progress I'm making, but I really don't exactly know how it takes place, how it functions, I don't know, it's pretty nebulous.

A: It probably has to be kept nebulous in order to avoid conflicts with me.

In one of the following sessions he spent more time talking about his father and the remarkable phenomenon that he had such a limited picture of him even though his father had worked at home as a craftsman for 10 years. He had grown up with the feeling of always standing outside the door. He had probably been disappointed that his father could never get his way against his mother. This time he mentioned not only his mother, but his father's mother, his grandmother. She was a woman in love with life and apparently enjoyed retirement; she came to them every day for her meals and spoiled the children with chocolate—which his father approved of but his mother criticized. His father apparently enjoyed the fact that the children were happy and being spoiled by their grandmother, who had grown mild in old age.

The patient had had a daydream after his father's death. In it he had seen an image of his father sitting in heaven and observed him masturbating. When he mentioned this image for the first time, it seemed as if his father had had a stern and evil look on his face. In today's session he attempted to differentiate, saying that it could be that the stern and evil aspects had been his mother and that his father had looked at him in a different way—as if he had felt a bond to him that was rooted in what his mother would never have accepted.

A: So it's conceivable that this image of your father in heaven portrays a connection, that something has stayed alive between the two of you and that you have bridged death in this way.

P: Yes, I wasn't able to mourn at all, I wasn't able to cry. Somehow it was as if I didn't have any use for it. I stood there in front of the door to the workshop and imagined that he was very far away.

The patient continued this line of thought, saying that this daydream might portray the wish to have received more encouragement from his father. He linked this to the fact that his mother had not permitted him to get a driver's license and that he had not had his way until he was away at the university.

At this juncture I pointed out to the patient that he had recently begun to furtively look around my room more and more, but had avoided me. I also pointed out that the treatment would be concluded sometime and that he then would again be in a situation like that when things between him and his father had not been out in the open. At this the patient became disturbed.

P: That's something I'd rather not think about yet; there are a few things I have to find out before I can go.

A: So that you won't only have stood outside the workshop door.

He then started to cry. I was surprised by his strong outburst of feelings because he had not been able to mourn. He is one of those people who rarely cry. Such moments of loosening up provide great relief, particularly in depressive personalities.

After the patient's crying had subsided somewhat, he said, "Those are moments when I have the feeling that there is never enough time. I can sense it: Our time is up again today." Although this was true, I had the impression that the patient also used the time limit to restrict himself and to keep from having any pleasurable fantasies about uniting with me. Therefore I

said, "Well, I always have ten seconds time for a bold thought if you dare to tell me one." At this he laughed in a very relaxed way, sat up, and enjoyed staying seated for a moment before he stood up and left the room.

While entering the room for the next session, the patient said, "Today I'm going to be very demanding." It was two minutes before the beginning of the session. The door was ajar, and I was sitting at my desk. He did not want to lie down immediately and sat on the couch, his legs spread apart. I found it strange to sit at my desk while he was sitting on the couch, and said, pointing to the two armchairs, "Then it might be more comfortable to sit over there." "Yes," he said, "today I want to take a good look at you. I have the feeling I don't know you well enough. I realized it recently when we met in town."

We continued on the topic of observing something, of looking very carefully. He didn't pick it up himself, but left it to me to say, "In that regard you have been very restrained." Yes, he said, he had never exactly asked himself whether this was a Freudian or a Jungian analysis. He mentioned that a friend of his had gone to a Jungian. The therapy was over now, and they were going sailing together. The question of whether something similar could happen to us was in the air.

A: And now you had to take a good look. Isn't that so? You think if I were a Freudian, then something of the sort probably could not happen.

P: No, I don't know enough about it at all. At the university I did read *The Interpretation of Dreams* once, but since then I haven't wanted to know anything about it. It's always bothered me when my friends turn to theoretical writings during a personal crisis. Yet, after all, [laughing] you probably have written something at some time, and I could go look for it.

A: Yes, you could.

Then he recalled that he had driven to his home town last Sunday and visited an old friend of his father. He had asked the old man, who was 80 years old, to tell him something

about his father. He hadn't spoken to the man for 25 years. He learned once again that his father had been injured in an accident and that he had gone about his work despite having great pain. The pain was caused by cancer, which was diagnosed when Friedrich Y was 6-7 years old; his father died when he was 13. Friedrich Y mentioned further that the Sunday walks had ceased when he was 6 or 7. After that his father had worked all the time, even on Sundays.

Subsequently he remembered a dream about an acquaintance with whom he had business contacts. This man had recently fallen from a fruit tree and was now tied to a wheelchair. In the dream he had thrown the man out of his wheelchair and rolled around with him on the ground, developing a feeling of tenderness in the process.

He was amazed at this because he otherwise had always had arguments and disagreements with this acquaintance. But he had the feeling that it had somehow done him good to reach out once. I linked this to his father and to the feeling that he had brought to this session, namely of being demanding. He laughed. He recalled that he currently did not need much sleep, that he woke up at 5:30 but did not dare to get up because his wife might wake up.

A: Yes, then your mother is sitting there in the room again and watching that you don't demand anything of your father, that means, that you don't go out jogging in the woods early in the morning when you wake up so early.

He thought about whether it had anything to do with the fact that his dose of lithium was already reduced to one tablet a day. Although he still needed a midday nap, he had the feeling that he needed less sleep at night and was strong enough to uproot trees.

Considering the responsibility that I shared for discontinuing the lithium medication, I inquired about his psychiatric consultations and the nature of his high spirits. On further reflection I came to view my concern in the framework of a countertransference reaction. I had sensed in this way that the patient was worried about whether he might act destructively when in closer contact, whether he might develop too much aggressiveness, whether he, in the cheerful mood accompanying his progress, might turn everything topsy-turvy. Not only his wife would be a victim of this expansiveness, but I as well. I therefore made the interpretation that

he was on the lookout for limits and restrictions.

From the beginning of the following session Friedrich Y was busy telling me that he had had a celebration on the weekend and was very satisfied with it, as he had been able to develop his professional role. The next night he had had a dream in which he saw himself hiking with his father and going into a shower room in a youth hostel, and that naked women had also been there, which came as a surprise to him. While he was still telling me about it, it became clear that he had enjoyed the view in the dream. Without directly associating to elements of the dream, he continued that he thought over and over again about his father being married twice although he hardly knew anything about his first wife. He had never been able to imagine that, in his father's second marriage, his father and mother ever had anything to do with one another. At his birth his father had already been 40. Laughing, he noted that this "already 40" was an unusual way of expressing premature aging and, in matter of fact hardly justified.

He continued thinking about his father, and now he also recalled that he had learned something from his father, specifically how to look at trees, to look at them like people. In contrast, his mother had insisted that he learn the names of plants and that he know the exact details of all the flowers. This was his mother's world. His father was much more alive when they walked through the woods. He said that his father had also shown him how to make small water wheels out of bark and twigs and that he could still do it, which he did with great enthusiasm.

After the image of his father had been blurred by the pane of frosted glass for a long time, it now seemed to brighten. This happened in direct correspondence to the increasing normalization of his interest in me (i.e., as an individual) and to the revitalization of childhood memories that now surfaced and became accessible to him.

I ended the session with the interpretation that in the dream he had apparently been able to express his wish that his father open his world of women to him. He might, as a boy, have felt that his father did not want to let him into it.

The patient started the following session by saying that he had finally been able to discuss

various problems with a colleague. He had expressed his complaints and reservations and dissociated himself, although he had noticed over and over again that he was concerned not to cause the colleague very much suffering.

He then remembered that while coming to the session he had thought about the title he would give his biography if he were to write one. The first detail he recalled was that as a child he had once released the hand brake of a hay wagon, which landed in a pile of manure. "Thus at some time," he said, "I must have been more able to do something like that, until I pulled the brake again. For twenty years I've been braking all the time."

I picked up his comment about being braked and his cautious attempt to release the hand brake and said, "Yes, you've recently made various attempts to release your brake, as well as to make some critical remarks here." This was a reference to the various attempts he had made to take a close look at me, and I had both many positive aspects and some critical ones in mind. To my surprise the patient picked up this line of thought:

P: Yes, for a long time now I've noticed out of the corner of my eye a microphone on the chair in front of you. I've asked myself whether you were planning to make a recording or whether you were even making a recording now. [Tape recordings were not made of this patient; this report is based on detailed notes taken during the sessions.]

A: Even though reason tells you that I wouldn't make any recordings here without your express approval, there seems to be a latent possibility now, a pleasurable idea that you could criticize me very intensely if I did such a thing behind your back.

P: Even though I don't believe you're capable of doing it, it would give me the opportunity here to start a real attack on you.

A: To become fierce.

P: Yes, to take the offensive. Incidentally, I wouldn't mind at all if you made tape recordings here. I can imagine that it's interesting for you.

Proceeding from this brief exchange, the patient returned to the topic of his profession and clearly indicated that he could be more outgoing in some gatherings. He could risk saying things in groups that he otherwise would only have secretly said to the colleague sitting next to him.

A: Yes, you're taking the initiative. You would like to open yourself to others.

P: Yes, I've probably kept many things to myself for too long. And even when I told my wife something, it wasn't enough. Something was incomplete.

The dialogue then returned to the therapeutic situation. The patient said once again, "Looking around in this room and perceiving personal things, it's a very difficult process for me."

Commentary. The course of this therapy raises a number of questions that deserve brief mention. The reader will have noticed the lack of speculation regarding the psychogenesis of the patient's illness as it manifested itself twenty years ago. It can nevertheless be clearly seen in the analyst's countertransference that he was nagged by substantial concerns about whether, after working through the clearly neurotic depressive conflicts, the anticipated release of expansive energy might lead to a destabilization of those sectors of the patient's personality that in psychoanalytic theories are associated with the genesis of psychotic conditions, in particular with manic ones (Abraham 1924; M. Klein 1935; Jacobson 1953, 1971). To understand the dynamics of this case, other components, especially the effects of the long-term administration of lithium on the patient's personality, a subject that has previously received little study, have to be taken into consideration (Rüger 1976, 1986; Danckwardt 1978; Schou 1986). Medication that works psychotropically inevitably has a psychodynamic effect in addition to its pharmacologic one. Lithium became, for this patient, the epitome of the prohibitive maternal principle. He plunged from typical adolescent hypomanic experiences, which for him were overpowering, and the medication provided the protective shield that he did not dare to question. With regard to technique, it was therefore important for the analyst, together with the patient, not to focus primarily on discontinuing the lithium treatment, but rather to initially focus on working on the

factors disturbing the patient's capacity to work that were linked to his difficulties with his father.

2.3.2 Brother Envy

The psychoanalytic situation stimulates a patient's needs that are rooted in the mother-infant relationship. This relationship, i.e., the mother-child template, constitutes the silent background that makes it inevitable that third parties—e.g., other patients—will at some time be experienced as trouble makers and rivals.

For Käthe X an unexpected pregnancy precipitated intense feelings, which may have stemmed from earlier moments when she had experienced envy and jealousy. Since the patient had a negative attitude toward being pregnant, the first signs of a pregnancy led her to pay increased attention to her own body and to show more interest in women who were pregnant or had just given birth. In the session of analysis described here a presumed childhood experience, which might have only been based on a single fictive memory, was linked to an stress situation she had experienced and to an antagonistic constellation in the therapeutic relationship.

At the beginning of the hour Käthe X described a visit she had paid to a colleague who had just given birth to a son. During the visit she had suddenly noticed her period had come. In her words, "I visit her in the hospital, and then this starts." When the young mother was supposed to nurse her child, Käthe X prodded a colleague who had come along into watching with her,

P: "Let's watch, I want to see this." I simply overpowered her.

A: Take a close look, just like you like to do.

Commentary. This remark was directed at one of the patient's strengths, which she had acquired in her defensive struggle against closeness and desires to fuse. She was particularly gifted in perceiving the personal details that create distance.

P: The colleague I visited is otherwise relatively thin. Now she's got real breasts. Makes her look good. I told my other colleagues about it. The baby is nice and has blue eyes. The others said, "Now it's your turn to have one."

The patient hesitated and became unsettled, so I said:

A: It makes you feel funny, completely different.

P: Yes, I'm all confused. That it starts bleeding now, funny, just like in menstruation.

Then she remembered an acquaintance who had had a miscarriage in the third month. I commented that the impressions she had had during the visit had confused her.

P: I've been to the hospital quite often. Actually, it didn't seem strange to me.

A: This time the situation was different, and you believe you're pregnant. It touches you very personally. The bleeding would mean that you aren't pregnant after all, a kind of negative decision.

Consideration. I hypothesized that there were psychic reasons that the patient had not become pregnant previously, yet she herself did not raise the topic.

P: Could be that I've deceived myself. The situation in the hospital room, the solemn mood. It was a dear child. [Pause] The father was also nice. The mother was a little pale. That's not really an impression that scares me.

Since the patient withdrew affectively from the current scene-which made a strong impression on me, inasmuch as I was familiar with the patient's life history—I decided to take an active step to tackle her avoidance and affective reattribution ("solemn mood") and asked a question linking the situation in the hospital with an experience in her past when the birth of her brother had forced her out of her parents' apartment when she was just 2 years old.

A: When Karl, your brother, was born, how must it have been then?

P: It happened at home. I heard it. It wasn't a difficult birth.

A: What does a 2-year-old hear?

P: No idea. I can't remember Karl until we had to go to the children's hospital a few months after he was born. That's the first thing I recall. I can still remember exactly how father pulled me on my sled to the hospital. Karl was in the hospital at the time.

Commentary. This early memory can be considered a relationship paradigm, in the sense described by Mayman and Faris (1960). This paradigm, on which Stiemerling (1974) has published a quantitative study of 500 people, represents the loss of the mother and an intimate relationship to the father.

A: Why was Karl in the hospital?

P: Don't know. Never interested me.

A: This time you were interested in your colleague and her baby. Why now?

P: Yes, I wanted to see the baby. Yes, what was the reason? I don't even have close contact to the colleague. I was interested in the baby and how the mother looks, how she has changed.

A: Just like we're interested in the changes that have recently begun to take place in your body.

P: Yes, yes. How she holds the baby in her arms. She is usually so unfeminine.

A: Well, if she manages to change, then . . . .

The patient interrupted me and continued my own line of thought.

P: Don't know what's wrong now. [Paused about one minute] Now I remember that I talked with colleagues yesterday about cats. We used to have cats. And a pregnant cat is always coming to me now. She's bound to have her kittens at our house. What should I do? A

colleague killed a young cat once, simply flushed it down the toilette. And now I'm beginning to feel very funny.

She was freezing, something that always happened when she had to confront stressful subjects that overwhelmed her resistance.

P: I recall that my mother once used the expression for a miscarriage, to flush it down the toilette.

A: It's hard to bear the thought.

P: Yes, my mother had her miscarriage when a letter made it impossible for her to overlook father's adultery. When mother told me, I thought to myself that she had killed the baby.

Commentary. Although this statement by the patient contains a highly ambivalent identification with her mother as her father's lover (inasmuch as the father involved the patient in allusions of an incestuous relationship), it also contains an identification with the aborted baby. She experienced herself to be the aborted baby, which also represented her wish that her brother had been aborted.

A: And something similar is in the offing for you, as if viewing the nursing mother made you aware of something that is completely unthinkable. The sight of Karl at your mother's breast, "If I could just get rid of him!" And your first association corresponds nicely. Karl was gone again and you were satisfied.

P: [Laughing] Yes, yes, that was the right place for him.

After thinking for a moment she again began to speak about her mother's miscarriage.

P: I regretted it. I would have liked to have seen it.

A: Since you couldn't prevent it, you could at least have seen it. What did the intruder look like? How did your mother look? Looking has become one of your strong points.

P: Has it? Do you think so?

The patient was touched by my reference to the fact that her "looking" was rooted in conflict. In my next intervention I therefore referred to a characteristic habit that the patient had often mentioned. She customarily arrived early, in order to see the previous patient leaving my office.

A: The way you look around my office, to see if everything is still in the same place or if I've changed something or removed anything.

P: [Correcting me] Yes, but I don't do it any more, it's different now. Today I've only looked at the potted plant.

The plant, a hibiscus, is on a toy box that I only use occasionally. In the subsequent long period of silence I felt I could sense how she gazed around the office. Inwardly I agreed with the patient that what she had said was very accurate, namely that she no longer felt the need, out of mistrust, to inspect the room and its contents for changes; in the meantime she had come to feel comfortable. Then she said matter of factly, "Interesting, the things a toy box can be used for!" Then she recalled a television film in which a boy was featured in two scenes playing with such a toy box: in one he flushed a baby down the toilette, in the other he let a crocodile eat it.

The thought of it made her shiver. She thought it was very bad, the poor baby. I chose, in contrast, to emphasize the aggressive element: "It upsets you to have to observe how this boy can openly give in to his impulses. That he simply eliminates the bothersome baby." The patient responded, "The boy was entirely aware of his rage at his mother, which was very intense." At the same time she made a powerful gesture, clasping her hands and rubbing them together.

P: I'm actually not as angry at my mother as I used to be, and have noticed that my husband and I almost rival for my mother's attention—which really amazes me.

She said this slightly mockingly, surprised because it used to seem completely inconceivable to her, although she had always clearly recognized that she envied her brother at how he managed to gain mother's favor. Mother gave him beautiful things, while she herself only got some money. She always gave Karl the things he had wished. But with her? She could tell her mother for days what she wanted, but it was of no use; her mother never remembered anything. "It's clear," she said, "Joseph [her husband] has taken Karl's place. I notice that I become envious of my husband and how my mother likes him."

Käthe X now summarized how her mother and husband agreed that she should be very happy to have managed to get somebody like him. Her mother simply had not given her enough attention.

A: Yes, we are concerned about whether the same feeling always returns, the feeling namely that somebody else gets my full support, and not you, and you have to make do with money.

P: I was already well on my way to seeing things here just like with my mother, to have just the same experiences.

She seemed to turn cold from inside and began to shiver.

P: When I imagine that the woman who's here before me always marches out with a happy look on her face, that would bother me very much. Then I would think that things are much better between you and her than between us.

Käthe X attributed, in transference, different roles to the previous patient, which were expressions of sibling rivalry. The conflict culminated in the patient identifying the other patient with her brother, which meant that the other patient would have to leave as soon as she felt better. The following interpretation picked up this line of thought: Her envy of the other patient, who should be sent away, would also be directed at herself if she openly displayed something positive.

A: This idea is a great burden on you. You can't permit yourself to be happy here, to make any progress, or at least only in a disguised way. I'm not supposed to notice that you're improving.

P: Yes, that's correct. My progress, I show it ouside. You can't see it then, and I can still be happy about it.

A: There's no danger in showing it to others.

P: But I also show it here. Because I'm happy when things change. But perhaps a little more carefully, cautiously.

In conclusion we will now discuss the patient's feeling of *envy for her brother* in more detail. If we raise the question as to why the patient envied her brother, we strike upon the feeling she repeatedly had as a child, of being excluded from the primary family, a feeling she had in connection with the birth of her brother. Because she had cried and whined a lot even as an infant, after the birth of her brother when she was two she was quartered out of her parents' apartment to her grandparents, who lived in the same house. The family's circumstances lead one to assume that she was an unwanted child and that the birth of her brother was linked to some extent with a normalization. It was thus natural to assume that the patient had received too little motherly attention instead of that she had a hypothetical envy for the "breast," and to assume that in the following years she had identified with this deficit in a way that made her angry and stubborn, as justified by her mother's behavior. There are, in fact, deficit experiences that can be strengthened or weakened by subsequent fantasies. This tension also characterizes the basic pattern of envy and jealousy that M. Klein studied retrospectively and linked to a two- or three-person relationship.

> Envy is basically directed at the productive strength: that which the envied breast has to offer is unconsciously taken as the prototype of the capacity to produce, because the breast and the milk that it provides are viewed as the source of life. (M. Klein 1962, p. 185)

As a result of infant research, the chronology of the manifestation of envy and jealousy is a matter of more controversy today, although in a different sense, than at the time of the great controversies between A. Freud and M. Klein (Steiner 1985). Micropsychological studies of the interaction between mother and child make it dubious that the process of splitting, which was linked to the handy metaphors of the "good" and "bad" breast, can be considered the cause of envy.

In contrast to the assumption that splitting involves very early intrapsychic processes, Stern's (1985, p. 252) results indicate that splitting is tied to later symbolic operations. Stern's criticism emphasizes the clinical relevance of splitting processes but severs them from their hypothetical anchoring in early infancy.

The frequently recurring experiences that occurred throughout the childhood of Käthe X led to an extension of the basic pattern: "If I am kind and good, they will keep me; if I am bad and stubborn, then they will drop me." Although a large number of such splitting processes—into good and bad—can be demonstrated in the case of this patient, they must be viewed as the outcome of a development in the course of which recurrent experiences led to the stabilization of this early fundamental experience. The modification of this unconscious schema in the transference situation—as the patient's reaction to another patient she considered in even greater need of assistance and with whom she could unconsciously identify—was an indication of the increase in underlying security that she had already gained in analysis. Rosenfeld (1987, p. 266) emphasized in a posthumously published work that envy is gradually reduced when the patient feels accepted by the analyst. He criticized, in hindsight, the typical Kleinian interpretations of envy, which lead to a dead end. Stereotype interpretations of envy make the patient feel humiliated, resulting in an antitherapeutic *circulus vitiosus* . If, in contrast, the patient feels that he has room for thinking and developing, his envy gradually decreases. Since Rosenfeld was a leading representative of the Kleinian approach, his late change of opinion might be of consequence for all of psychoanalysis.

2.4 Transference and Identification

2.4.1 The Analyst As Object and As Subject

Freud's demand that "the patient should be educated to liberate and fulfill his own nature, not to resemble ourselves" (1919a, p. 165) seems to contradict the large, decisive therapeutic significance of the patient's identification with the analyst. At a symposium on the termination of analyses, Hoffer (1950) declared the patient's capacity to identify with the psychoanalyst's functions to be the essential component of the therapeutic process and its success. This topic is thus of fundamental importance for an understanding of the therapeutic process and for the tension between the poles characterized in the following quotations:

> We serve the patient in various functions, as an authority and as substitute for his parents, as a teacher and educator . . . .However much that analyst may be tempted to become a teacher, model and ideal for other people and to create men in his own image, he should not forget that that is not his task in the analytic relationship, and indeed that he will be disloyal to his task if he allows himself to be led on by his inclinations. (Freud 1940a, pp. 175, 181)

Yet this raises a number of questions. What does the patient identify with? What are the consequences of the psychoanalytic theory of identification for the optimization of therapy in the sense of facilitating the patient's task of grasping the analyst's functions? What does the psychoanalyst contribute, and how? Is it possible, with regard to the patient's experiencing, to distinguish the functions from the person embodying them? What is the relationship between identification and the demand that the transference neurosis be resolved at the end of analysis?

Identifications with persons from the patient's past are repeated with the object of transference. For various reasons it is useful to distinguish between the analyst's roles as transference object and as a subject. Significant persons from the past become inner "object representations" and ally themselves with "self representations." These inner images and the effects they have on experiencing and behavior form the starting point of the process that Freud

(1900a) referred to as the reestablishment of "perceptual identity." This affective-cognitive process leads to the rearrangement of current relations according to old patterns. It follows from this that the patient, on the basis of his unconscious disposition, also attributes roles to the doctor. In the constellation of transference neurosis the analyst can feel the strong pressure that the patient exerts to compel the analyst to accept a role. The patient would like to get to know the psychoanalyst in order to be able to identify himself with him, e. g., as an idealized object. The other person's subjectivity is not taken into consideration in these unconsciously governed and powerful attempts to reestablish a perceptual identity; the other person is made into an "object." By going along with this, the psychoanalyst can recognize the discrepancy between what is attributed to him and what he is. In this way he acquires the knowledge that makes it easier for him to make transference interpretations, as described particularly by F. Morgenthaler (1978). As a result of transference interpretations the past becomes present, opening new opportunities and perspectives.

Qualifying the psychoanalyst as a "new object" thus in our view does not go far enough (Loewald 1960). Although, according to psychoanalytic theory and terminology, the "object" comprehends the "subject," the development of a psychoanalytic "personology" (a two- or more-person psychology) requires that the subjective nature of individuals be fully acknowledged. The analyst fulfills his therapeutic function as a genuine subject and only in part by letting himself be made into an object.

The attempt to avoid directly influencing the patient has, in connection with Freud's mirror metaphor, contributed to the fact that the role identificatory processes play in therapy has been neglected although they have great significance for a cure. We want to modify rigidified and sedimented "object identifications" by helping the patient make new experiences. The subject pursuing this goal, i.e., the analyst, must be acceptable to the patient; he should not stand out among the "average expected environments" in the sense described by Hartmann (1939), in order not to precipitate xenophobic reactions. However since the special status of the

psychoanalytic dyad differs substantially from routinized communication, in which only clichés are exchanged and which is itself a kind of mirroring of a rigidified state, the situation is novel, characterized by a quality of strangeness.

Although the transference neurotic repetition—itself strongly dependent on the situative conditions created by the psychoanalyst—determines the form and content of observable phenomena, the identification with the psychoanalyst's functions provides insight into previously unknown, unconscious connections and new experiences. Sterba (1940, originally published in 1929) emphasized the therapeutic significance of identification in an early article which, in contrast to his later publication (1934) on therapeutic ego splitting, has remained relatively unknown.

> The analyst assists the ego, attacked by the id, offering it the possibility of an identification which satisfies the reality testing needs of the ego. This identification of the reality testing parts of the patient's ego is made possible by the fact that the analyst continuously observes and interprets to the patient the psychological situation without prejudice.
>
> The invitation to this identification comes from the analyst. From the beginning of treatment, comments are made by the analyst about the work they will have to accomplish in common during the cure. Many phrases such as, "Let us recall what you dreamed, or thought, or did there," used by the analyst contain this invitation to identification with him as it is implied every time the analyst uses "we" to refer to the patient and himself. This identification with the analyst is based first on the patient's wish for recovery and second on the positive transference . . . .This identification is based finally on a narcissistic satisfaction resulting from *his participation in the intellectual work of gaining insight* during the analysis. (Sterba 1940, p. 371, emphasis added)

In this passage Sterba came close to recognizing the important fact that the identification can also be directed at the joint work and not just at an object. Thus the form of communication that can lead the patient out of the neurosis is itself one of the major issues.

Although the intensified formation of "we-bonds" is to a certain extent not unproblematic,

because it can have a seductive effect or make contradiction and independence more difficult, we nevertheless believe that the "standard technique's" understanding of psychoanalytic rules has impeded the identification with the psychoanalyst's functions and the formation of we-bonds as called for by Sterba. The primary unity of person and function is associated with complications, which in our opinion can be resolved in the course of treatment, e.g., in identification leading to the adoption of self-reflection. The opposite attempt, namely to carry the incognito to an extreme and provide the therapeutic functions impersonally, fails for anthropological and psychoanalytic-psychogenetic reasons.

The fact that we put things in a new context and thus give them a new meaning always implies that we inform the patient of our views and divulge ourselves personally. Since, from a psychoanalytic perspective, an individual's personal identity develops both from within to without and from without to within, there are often limits on how much external influence can be exerted, and not only for practical reasons. Although we reject a purely social psychological explanation of identity development (from without to within), its theses, as argued for example by Luckmann, have serious consequences for our understanding of interpersonal mirroring.

> An individual does not experience himself in an unmediated way. Only the environment can experience an individual in an unmediated way, only the environment gives itself to consciousness directly. An individual experiences others in social relationships. These others are given, unmediated, by their physical presence. The physical presence of fellow humans (or more generally, of others) is taken as a field for expressing their conscious processes. Yet insofar as the other's experiences are directed back at him, "the individual is mirrored in his fellow humans." In social relationships, which take place in a common environment, the individual experiences himself via his fellow humans. The capacity for interactive mirroring is the fundamental condition for the individual human being to form a personal identity. (Luckmann 1979, p. 299)

This understanding of mirroring makes it possible to grasp Freud's mirror metaphor in the sense of mediated self-reflection (see Vol.1, Sect. 8.4).

Yet there are a number of questions regarding the modified mirror metaphor that cannot go

unmentioned even if answering them goes beyond the framework of the cases discussed in the following sections. The form of communication—therapeutically helpful and leading to changes—that is conceptualized as "mediated self-reflection" is inadequate both theoretically and practically because more is involved than the perception of previously unconscious "contents" and the emotions linked with them that are conveyed to the patient. Discovery and rediscovery take place within the framework of a special form of communication that makes it possible for the patient to find a new relationship to himself. The nature of the relationship that the psychoanalyst exhibits toward unconscious material—and this implies *his* relationship to himself, as elaborated by Tugendhat (1979)—becomes the model for the process of transformation that also changes the patient's relationship to himself.

2.4.2 Identification with the Analyst's Functions

Amalie X came to psychoanalysis because the severe restrictions she felt on her self-esteem had reached the level of depression in the last few years. Her entire life history since puberty and her social role as a woman had suffered from the severe strain resulting from her hirsutism. Although it had been possible for her to hide her stigma—the virile growth of hair all over her body—from others, the cosmetic aids she used had not raised her self-esteem or eliminated her extreme social insecurity (Goffman 1974). Her feeling of being stigmatized and her neurotic symptoms, which had already been manifest before puberty, strengthened each other in a vicious circle; scruples from compulsion neurosis and different symptoms of anxiety neurosis impeded her personal relationships and, most importantly, kept the patient from forming closer heterosexual friendships.

The analyst offered this woman, who was hard working in her career, cultivated, single, and quite feminine despite her stigma, treatment because he was relatively sure and confident that it would be possible to change the significations she attributed to her stigma. In general terms, he proceeded from the position that our body is not our only destiny and that the attitude which

significant others and we ourselves have to our bodies can also be decisive. Freud's (1912d, p. 189) paraphrase of Napolean's expression to the effect that our anatomy is our destiny must be modified as a consequence of psychoanalytic insights into the psychogenesis of sexual identity. Sexual role and core identity originate under the influence of psychosocial factors on the basis of one's somatic sex (see Lichtenstein 1961; Stoller 1968, 1975; Kubie 1974).

Clinical experience justified the following assumptions. A virile stigma strengthens penis envy and reactivates oedipal conflicts. If the patient's wish to be a man had materialized, her hermaphroditic body scheme would have become free of conflict. The question "Am I a man or a woman?" would then have been answered; her insecurity regarding her identity, which was continuously reinforced by her stigma, would have been eliminated; and self image and physical reality would then have been in agreement. It was impossible for her to maintain her unconscious fantasy, however, in view of physical reality. A virile stigma does not make a man of a woman. Regressive solutions such as reaching an inner security despite her masculine stigma by identifiying herself with her mother revitalized old mother-daughter conflicts and led to a variety of defensive processes. All of her affective and cognitive processes were marked by ambivalence, so that she had difficulty, for example, deciding between different colors when shopping because she linked them with the qualities of masculine or feminine.

When structuring the psychoanalytic situation and dealing with such problems, the analyst must pay extra attention to not letting the asymmetry of the relationship excessively strengthen the patient's feeling of being different. This is important because the idea of being different—that is, the question of similarity and difference, of identity and nonidentity—forms the general framework within which unconscious problems appear. In this case the analyst and patient succeeded relatively quickly in establishing a good working relationship, creating the preconditions for recognizing the internalization of earlier forms of interaction with primary reference persons—parents and teachers—during the development of the transference neurosis. The correction that was achieved can be seen in the changes in her self-esteem, in her increased

security, and in the disappearance of her symptoms (see Neudert et al. 1987).

The two excerpts of treatment given below are linked, despite the time that elapsed between them, by the fact that each is concerned with enabling the patient to make new identifications as a result of the analysis of transference. The analyst's "head" became the surrogate of old, unconscious "objects," and its contents the representative of new opportunities. The representation on the "object," which is simultaneously self-representation, made it possible to establish a distance because the analyst made his head available and kept it too. Thus he became a model for closeness and distance. This example clearly demonstrates the therapeutic effect that insight into the connections between the analyst's perceptions and thoughts can have.

We have selected this case because in our opinion it is suited to provide several lines of support to our argument. Although the head acquired sexual importance as a result of the process of unconscious displacement, this displacement did not alter anything regarding the primacy of intellectual communication between the patient and the analyst about what was sought hidden inside the head. The search for knowledge was directed at sexuality. This secret and well-guarded (repressed) treasure was assumed to be in the head (as the object of transference) because of the unconscious displacement. The rediscovery of "displacement" brought something to light that was "new" to the patient.

The ideas that formed the background for my interpretations are given in addition to the abridged verbatim dialogue. These "Considerations" were subsequently added to the interpretations and the patient's responses. It is obvious that I was led not only by the ideas described here when I arrived at my interpretations. However interpretations may be created, any interpretation actually made to the patient must be aligned along "cognitive" criteria, as demanded by Arlow (1979). My comments refer to the "cognitively" and "rationally" groundable "end products"—my interpretations—and neglect their genesis and the intuitive, unconscious

components in their genesis. The source of each of my analytic thoughts thus remains open. If we assume that the analyst's perceptive apparatus is steered by his theoretical knowledge, which may have become preconscious, then it is very difficult to trace the genesis of interpretations back to their "beginnings." For example, theoretical knowledge about displacement also facilitates preconscious perception; it pervades the analyst's intuition and blends with the countertransference (in a wider sense).

The patient suffered from severe feelings of guilt, which were actualized in her relationship to me. The Biblical law of an eye for an eye and a tooth for a tooth was reinforced in her experiencing because of her sexual desires. Her life historical role model for the contents of her transference neurosis was a fantasized incestuous relationship to her brother. The increase in inner tension led the patient to reconsider the idea of dedicating her life to the church as a missionary or to contemplate committing suicide. (As a young girl she had wanted to become a nun and nurse but given up this idea after a trial period because the pious confinement became too much for her. Leaving also helped her establish some distance to the strict Biblical commandments.) Now she wielded her "old" Bible against me, "in a fight to the finish." This fight took place at different levels, and the patient invented a series of similes for them. She had the feeling that the analyst's dogma, the "Freud Bible," could not be reconciled with her Christian Bible. Both bibles, however, contained a prohibition of sexual relations with the analyst.

The patient struggled for her independence and needs, which she defended against both of these bibles. She developed an intense defense against my interpretations, and she had the feeling that I knew in advance exactly "what's going to happen." She felt humiliated because her detours and distractions had been detected. She had the intense desire to mean something to me and to live in me; she thought about giving me an old, lovely, and wonderful clock that would strike every hour for me (and for her).

In this phase of treatment one topic took on special significance and intensity; this was her interest for my head. What had she learned from measuring my head? In a similar situation

Amalie X had once said that for a long time she had thought that I was looking for confirmation of what was already there—in books, in my thoughts, in my head. She wished that something completely new would come out. She herself looked for interpretations and made an effort to understand my ideas.

The patient mentioned her strict boss, who had unjustly criticized her and for whom she was no match.

A: You presume that I'm sitting behind you and saying "wrong, wrong."

Consideration. This transference interpretation was based on the following assumption. The patient attributed me a "superego function." This interpretation took the burden off her and gave her the courage to rebel (the patient had recognized long before that I was different and would not criticize her, but she was not sure and could not believe it because she still had considerable unconscious aggressions against old objects). I assumed that she had much more intense transference feelings and that both the patient and I could tolerate an increase in tension. I repeated her concern that I could not bear it and finally formulated the following statement: "Thus it's a kind of a fight to the finish, with a knife" (not specifying who has the knife). I meant for this allusion to phallic symbolism to stimulate her unconscious desires. It was an overdose! The patient reacted by withdrawing. Assumption: self-punishment.

P: Sometimes I have the feeling that I would like to rush at you, grab your neck, and hold you tight. Then I think, "He can't take it and will suddenly fall over dead.

A: That I can't take it.

The patient varied this topic, expressing her overall concern about asking too much of me and of my not being able to take the struggle.

A: It's a kind of a fight to the finish, with a knife.

P: Probably.

She then reflected that she had always, throughout the years, given up prematurely, before the struggle had really begun, and withdrawn.

P: And I don't doubt any more that it was right for me to withdraw. After such a long time I have the urge to give up again.

A: Withdrawal and self-sacrifice in the service of the mission instead of struggling to the end.

P: Exactly, nerve racking.

Consideration. She was very anxious about losing her object.

A: Then I would have the guarantee of being preserved. Then you would have broken off my test prematurely.

We continued on the topic of what I can take and whether I let myself be carried along by her "delusion." The patient had previously made comparisons to a tree, asking whether she could take anything from it, and what it would be. I returned to this image and raised the question of what she wanted to take along by breaking off branches.

Consideration. Tree of knowledge—aggression.

P: It's your neck, it's your head. I'm often preoccupied with your head.

A: Does it stay on? You're often preoccupied with my head?

P: Yes, yes, incredibly often. From the beginning I've measured it in every direction.

A: Hum, it is . . . .

P: It's peculiar, from the back to the front and from the bottom. I believe I'm practicing a real cult with your head. This is just too funny. With other people I'm more likely to see what they have on, just instinctively, without having to study them.

Consideration. Create shared things as primary identification. [This topic was discussed for a

long period of time, with some pauses and "hums" by the analyst.]

P: It's simply too much for me. I sometimes ask myself afterwards why I didn't see it, it's such a simple connection. I am incredibly interested in your head. Naturally, what's inside too. No, not just to take it along, but to get inside your head, yes above all, to get inside.

Consideration. The partial withdrawal of the object increased her unconscious phallic aggressiveness.

The patient spoke so softly that I did not even understand "get inside" at first, mistaking it for "put inside." The patient corrected me and added a peculiar image, "Yes, it's so hard to say in front of 100 eyes."

P: Get inside, the point is to get inside and to get something out.

I saw this getting inside and taking something out in connection with the subject of fighting. It was possible to put the sexual symbolism resulting from the displacement from the bottom to the top to therapeutic use by referring to a story that the patient had told in an earlier session. A woman she knew had prevented her boyfriend from having intercourse with her and had masturbated him, which she had described by analogy to head hunter jargon as "head shrinking." The unconscious castration intention dictated by her penis envy created profound sexual anxiety and was paralleled by general and specific defloration anxieties. These anxieties led in turn to frustration, but one which she herself had instinctively caused, as a neurotic self-perpetuating cycle. The rejection of her sexual and erotic desires that now occurred unconsciously strengthened the aggressive components of her wanting to have and possess (penis desire and penis envy).

A: That you want to have the knife in order to be able to force your way in, in order to get more out.

After we exchanged a few more thoughts, I gave an explanation, saying that there was something very concrete behind our concern with the topics of getting inside, head, and the

fight to the end with a knife.

A: The woman you mentioned didn't speak of head shrinkers for nothing.

P: That's just the reason I broke off this line of thought. [For about ten minutes the patient had switched to a completely different subject.]

After expressing her insight into her resistance to an intensification of transference, she again evaded the topic. She interrupted the intensification, making numerous critical comments.

P: Because at the moment it can be so stupid, so distant. Yes, my wishes and desires are the point, but it's tricky, and I get real mad, and when head and head shrinking are now . . . .

She laughed, immediately expressed her regret, and was silent. I attempted to encourage her.

A: You know what's in your head.

P: Right now I'm not at all at home in mine. How do I know what will happen tomorrow. I have to think back. I was just on dogma and your head, and if you want to go down . . .[to a shrunken head]. It's really grotesque.

Consideration. I first mentioned the shrunken heads because I assumed that the patient would be more cooperative if the envious object relationship could be replaced by a pleasurable one.

Then the patient came to speak of external things. She described how she saw me and how she saw herself, independent of the head, which then again became the focus of attention in a general sense.

A: By thinking about the head you're attempting to find out what you are and what I am.

P: I sometimes measure your head as if I wanted to bend your brain.

The patient then described the associations she had once had when she had seen my picture printed somewhere.

P: I discovered something completely different at the time. There was an incredible amount of envy of your head. An incredible amount. Now I'm getting somewhere at any rate. Whenever I think of the dagger and of some lovely dream.

Consideration. The patient obviously felt caught. She felt humiliated by her own association, as if she had guessed my assumption as to what the envy might refer to. In this case I would have rushed ahead of her, so to speak.

A: Humiliating, apparently to you, as if I already knew which category to put it in when you express envy, as if I already knew what you are envious of.

P: That came just now because you had referred to the shrunken heads, which I didn't even make. But what fascinated me is this fight to the finish, for the knife, to get to the hard part . . . .Yes, I was afraid that you couldn't take it. My fear that you can't take it is very old. My father could never take anything. You wouldn't believe how bland I think my father is. He couldn't take anything.

Consideration. A surprising turn. The patient's insecurity and her anxiety about taking hold developed "unspecifically" on her father.

A: It's all the more important whether my head is hard. That increases the hardness when you take hold.

P: Yes, you can take hold harder . . .and can—simply—fight better.

The patient then made numerous comments to the effect of how important it was that I did not let myself be capsized, and she returned to her envy. Then she mentioned her university studies again, and how she used to "measure" the heads of the others. Then she introduced a new thought.

P: I want to cut a little hole in your head and put in some of my thoughts.

Consideration. An objectivistic image of "intellectual" exchange as a displacement?

The patient's idea about the two-sided nature of the exchange led me to recognize another aspect of this fight. It was also an expression of how important it was to me that she remain a part of the world (and in contact with me), and digress neither into masochistic self-sacrifice nor into suicide.

P: That came to me recently. Couldn't I exchange a little of your dogma for mine. The thought of such an exchange made it easier for me to say all of this about your head.

A: That you continue coming here so that you can continue filling my head with your thoughts.

Consideration. Fertilization in numerous senses—balance and acknowledgment of reciprocity.

P: Oh yes, and mentioning really productive ideas.

The patient returned to the thoughts and fantasies she had had before the session, about how she had been torn back and forth. Whether she had a future at all, and whether she shouldn't withdraw in some way or other and put an end to it all.

At the beginning I had attempted to relieve her intense feelings of guilt with regard to her destructiveness. I picked up the idea once again that her thoughts about my stability were in proportion to her degree of aggressiveness. The patient could only gain security and further unfold her destructiveness if she found strong, unshakable stability. The topic of dogmatism probably belonged in this context. Although she criticized it—both her own Bible and my presumed belief in the Freud bible—it also provided her security, and for this reason the dogmatism could not be too rigorous or pronounced.

A: Naturally you wouldn't like a small hole; you would like to put in a lot, not a little. The idea of a small or large hole was your shy attempt to test my head's stability.

My subsequent interpretation was that the patient could also see more through a larger

hole and could touch it. She picked up this idea:

P: I would even like to be able to go for a walk in your head.

She elaborated on this idea and emphasized that even earlier, i.e., before that day's session, she had often thought to herself how nice it would be to relax in me, to have a bench in my head. Very peacefully she mentioned that I could say, when looking back on my life when I die, that I had had a lovely, quiet, and peaceful place to work.

Consideration. Quiet and peacefulness clearly had a regressive quality, namely of completely avoiding the struggle for life.

The patient now viewed her entering the motherhouse as if a door had been wide open and she had turned away from life. She then drew a parallel to the beginning of the session, when the door was open.

P: I really didn't have to drill my way in. Yes, there I could leave the struggle outside, I could also leave you outside, and you could keep your dogmas.

A: Hum.

P: And then I wouldn't fight with you.

A: Yes, but then you and your dogma would not be afraid of mine. In that setting of peace and quiet everything would remain unchanged, but the fact that you interfere in my thoughts and enter my head shows that you do want to change something, that you can and want to change something.

About five minutes into the next session, the patient returned to my head and measuring it and to the fact that it had disturbed her that I had started talking about the shrunken heads.

P: I told you so. Why do you simply want to slip down from the head?

She then described how she had hardly arrived at home before she recalled the thoughts

she had had when she had said hello but then had completely forgotten during the session.

P: To me, he [the analyst] looks as if he is in his prime, and then I thought about the genitals and the shrunken heads. [But she quickly pushed this thought aside, and it was completely gone.] When you started with the shrunken heads, I thought, "Where has he got that again?"

The next topic was the question of my security and my dogmatism, and it was clear that the patient had taken a comment I had once completely undogmatically made about Freud and Jung (I have forgotten what it was) to be dogmatic. She then thought about living a full life, about the moment when everything stopped for her and she became "ascetic," and about whether everything could be revived. Then she again mentioned fighting and my head.

P: I was really afraid of tearing it off. And today I think that it's so stiff and straight, and I think to myself, "I somehow can't really get into my head. I'm not at home. Then how should I get into yours?"

The patient then began to speak about an aunt who was sometimes so very hard that you might think you were facing a wall. She then continued about how hard and how soft she would like her head to be. Her fantasies revolved, on the one hand, around quiet and security; on the other hand, she was concerned about what might be hidden in her head and the danger of it consuming her.

Consideration. This obviously involved a regressive movement. The patient could not find any quiet and relaxation because her sexual desires were linked with pregenital fantasies, which returned in projected form because they were in danger of being consumed. These components were given their clearest, and in a certain sense also their ultimate, expression in an Indian story the patient later associated, in which mothers gave pleasure to their little sons by sucking on their penises but bit them off in the process.

The comparisons of the heads and their contents always revolved around the question of whether they went together or not.

P: The question of how you have your thoughts and how I have mine . . . .Thoughts stand for many things . . . .

A: How they meet, how they rub off on one another, how far they penetrate, how friendly or unfriendly they are.

P: Yes, exactly.

A: Hum, well.

P: You said that a little too smooth.

The patient thought about all the things that scared her and returned again to the shrunken heads.

P: There I feel too tied to sexuality. The jump was too big.

The topic was continued in the question of her speed and of the consideration I pay to her and her speed.

P: But it is true; naturally it wasn't just your head but your penis too.

Amalie X was now in a position, with phases of increasing and receding anxiety, to distinguish between pleasure from discovering intellectual connections and sexual pleasure. The couch became her mental location of sexual union, and her resting in my head the symbol of pregenital harmony and ultimately the location of shared elements and insight. This aspect became even clearer a little later.

With regard to the patient's symptoms, the topic of the sessions was characterized by her anxiety about having injured herself, which was a reaction to a harmless cystitis. The patient suffered from a constant urge to urinate, which she assumed might be the result of having injured herself while masturbating. With the aid of anatomy books, she had tried to imagine her genital region. She localized her complaints to her entire abdomen. She imagined that she

had destroyed a muscle by pushing and rubbing it, similar to how the sphincter muscle of the bladder can be damaged during difficult births. The patient was greatly disturbed by this anxiety, and her sleep and capacity to work were also disturbed. She was afraid that someone might notice a wet spot on her pants. Destructive fantasies predominated in her masturbation.

Despite her growing complaints the patient showed trust. She expected a clear answer about whether it was anatomically possible for her to have injured herself while masturbating. My assurance that this was not the case reduced her anxiety and temporarily provided her with great relief but also with the feeling of having blackmailed me or of having "somehow seduced me." This was to be a source of "new dangers." Blackmail, confession, and seduction became mixed. She was afraid that I would "lead her somewhere where everything was permitted," as if there were no place for guilt in my point of view. The patient alternated between two images; in one she viewed me as the seducer, in the other as the judge of public morals. Retreating to pious religiosity seemed to her the way to escape the threatening boundlessness in herself, which would muddle and destroy everything. Yet her religiosity still meant little to her, especially since she had loosened her ties to the church prior to analysis because she had not felt any relief of her distress but repeatedly felt new stress from the commandments.

In this phase there was a decisive turn in the relation between transference and doctor-patient relationship, which resulted from the fact that I had offered an explanation for my technique. Amalie X took this as a sign of my trust. This facilitated her identification with my function as analyst of providing insights. My willingness to inform her of my thoughts, which appeared to her as a special treasure, raised both the relationship and the transference to a new level. Having a view and being able to gain insights, i.e., being less excluded, made her aggressive intruding into my "head," her drilling a hole, superfluous, or in other words brought us closer together and let her participate at a friendly, pleasurable, playful level.

It is nothing special for me to offer a patient insight into my psychoanalytic thinking. In my view it is a completely banal situation, which however might provide the patient an entirely new experience. In a displaced transference to her supervisor she exhibited an "immense respect," as shown by her boss' lack of time, which did not permit her to clarify a small dispute in

another talk.

The patient apparently experienced the trust I showed as an sign of great freedom, as if I had freed myself from some inhibition. Then we worked through the fact that she had known for a long time what my opinion about important items in her experiencing was and that she was in fact entitled to intrude and know.

The patient mentioned a problem with her boss and made it clear that she felt freer toward him. She attributed her success in an exaggerated way to psychoanalysis and to me. Then we turned to the question of encouragement and I said that the wish she expressed for encouragement deprived her of being able to enjoy her own success. The session continued about the excessive respect she still had.

A: That is getting quite a bit smaller by itself.

P: I still have a terrible fear of being thrown out.

(For a long period of time the patient had regularly left my office a few minutes before the end of the session, creating a minisymptom. The numerous determinants of this behavior were never a particular topic of concern. The patient's behavior changed by itself step by step. Among other things, the patient wanted to avoid being sent away, which could "annul" an entire meeting.)

To my surprise the patient asked, "Have you noticed that you've just given me an explanation for your technique, something you rarely do?" In response to a question, I find out that the patient was impressed by my statement that something decreases of its own accord. (In retrospect, I thus did give her encouragement, namely that many things happen on their own and not everything has to be fought for.) The patient then spoke for a long time about how unusually positive she had experienced my statement to be and that she viewed it as an sign of my freedom.

P: Don't you like the freedom that I attribute to you?

I showed my surprise at her belief that she was not supposed to intrude in my thoughts and learn the reasons for my statements and ideas, although she had known this for a long time.

P: But that I could say it, that is what I found incredibly new.

A: Then it is almost as if my saying that you may know something that is completely natural and that you have known for a long time was a sign of approval.

P: There was more to it, namely the image you've always had for me, simply that you protect your treasure. [She laughed.] I've always had the feeling . . .head, book, and all the things, and when you open your own head, then I don't have to drill, and that is simply something completely different. It's just an openness or freedom that exudes from you. A proof of trust, I think, when you say, "I do it for this and that reason . . . .I think it is this or that." It seems to be different if you say it or if I say it to you.

With regard to the open book it must be added that the patient in the meantime had read a publication of mine and a second one I had jointly authored with my wife. The patient had somehow attributed commandments prohibiting the acquisition of knowledge to the "Freud bible," and she was apparently surprised that I viewed her curiosity as something natural, just like her gathering of information about my family background. And with regard to my Christian Bible, even before beginning analysis she had had a vague idea about my far-reaching family ties.

New and more intense transference fantasies developed with the increase in the patient's trust and her identification with my function as analyst in helping her achieve insights. A continuous working relationship was thus assured, which was symbolized by the "stable, reliable face," by the "I-am-there-face" of the psychoanalyst, and by his "warm hands."